**Measurement and treatment outcomes for gambling harm treatment services**

**Report prepared for Health New Zealand | Te Whatu Ora**

**Prepared by**

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# Executive Summary

This document provides recommendations for outcome measurement in gambling harm treatment services in New Zealand. It is intended to be a practical resource for Health New Zealand | Te Whatu Ora in identifying appropriate measures for a "minimum dataset" tailored to these services. The focus is not on providing a comprehensive review of all instruments or research findings but on offering guidance for selecting measures that are practical, relevant, and evidence based.

The primary objective of this document was to review and identify gambling-related measures suitable for assessing outcomes for people who gamble and their affected others in treatment services. It recommends instruments for inclusion in a minimum dataset specifically tailored for use in New Zealand gambling harm services. These recommendations are informed by a review of Ministry of Health (MOH) and service documents, as well as a secondary data analysis of clinician therapeutic approaches in New Zealand. In this secondary data analysis, we found that treatment for people with problem gambling in New Zealand primarily involves Cognitive Behavioural Therapy (CBT) and Motivational Interviewing (MI) and focused on holistic conceptualisations of recovery, including wellness.

To inform the selection of measures, a literature search was conducted using key terms such as "gambling," "measurement," "systematic review," "meta-analysis," and "consensus guidelines." This search identified twelve reviews on gambling screening and outcome measurement, as well as three reviews focused on affected others.

The development of the minimum dataset was guided by several considerations to ensure practicality and relevance for gambling harm treatment services in New Zealand, including client and clinician burden in terms of time, the selection of outcomes that are aligned with contemporary treatment practices, including an emphasis on wellness and recovery, alignment with CBT and MI, screening for psychological issues, and applicability of constructs to all clients. Moreover, several criteria were developed for selecting measures for the minimum dataset. These included: current use in New Zealand services, psychometric properties (reliability, validity, classification accuracy, and sensitivity to change), cultural suitability, self-report administration, brevity, and availability in the public domain at low-cost.

Over 80 measures were extracted from the review studies and assessed against these criteria. Measures with poor psychometric properties, excessive length (more than five items for intake/screening or more than fifteen items for other measures), or misaligned constructs were excluded. About 30% of measures were rejected based on length alone. Those meeting the criteria were included in a long list for further evaluation.

For clients who gamble, the minimum dataset included intake and screening measures: (i) describing client characteristics, including the level of gambling harm; and (ii) assessing risk, screening for psychiatric comorbidity, and informing referral to other services (suicidal ideation, family/whānau violence, hazardous alcohol use, other drug use, and excessive gaming). Client outcomes included measures: (iii) evaluating the impact of treatment on both gambling outcomes (gambling symptoms, gambling behaviour, and treatment goal achievement) and non-gambling outcomes (depression symptoms, anxiety symptoms, functional impairment and wellbeing/quality of life; (iv) that can be employed in treatment planning or to evaluate the processes or mechanisms of change (i.e., the targets of CBT and MI that can be viewed as secondary outcomes), including readiness to change, gambling cognitions, and gambling urges. Finally, we recommended the inclusion of a measure of client satisfaction. The key recommendations include measuring harms with the Domain-General Harms Scale, which assesses harm across the multiple domains of harm and replacing the Problem Gambling Severity Index (PGSI) as the primary outcome measure with the Gambling Symptom Assessment Scale (G-SAS). Like the PGSI, the G-SAS measures both behavioural dependence (e.g., chasing losses, tolerance, withdrawal symptoms) and negative consequences, but has a much shorter timeframe and was specifically designed to measure the outcomes of treatment.

Similarly, for affected others, the minimum dataset included intake and screening measures: (i) describing client characteristics, including the level of gambling harm; and (ii) employing the same set of brief screening instruments as those employed for gamblers, with excessive gaming removed and own gambling symptoms added. Outcomes included measures: (iii) evaluating the impact of treatment on both affected other-focused outcomes (depression symptoms, anxiety symptoms, stress symptoms, functional impairment, and wellbeing/quality of life) and the more gambler-focused outcome of gambling support self-efficacy. Measures of coping and social support were included to support treatment planning and to evaluate the processes or mechanisms of change and a brief client satisfaction questionnaire is also recommended for affected others.

The report includes the two reviews and a long list of measures, providing alternatives for situations where a different measure may be preferred. Detailed justifications for each measure are included in the report and the actual items are included in the appendices of this document.

# Recommended minimum datasets

## Recommended minimum dataset for the person who gambles

|  |  |  |  |
| --- | --- | --- | --- |
| Intake and screening - gambling |  | Number of items | 19 |
|  | Expected time | 3-5 minutes |
| Repeated outcome monitoring – gambling |  | Number of items | 47 |
|  | Expected time | 10 minutes |

**INTAKE AND SCREENING – GAMBLER**

|  |  |  |  |
| --- | --- | --- | --- |
| **Domain** | **Construct** | **Measures** | **No. of items** |
| Measurement to describe people who gamble and are accessing the service | Gambling activity causing harm | GAMTOMS - Q20 | 1 |
| Gambling modality causing harm | Bespoke single item | 1 |
| Gambling harms | Domain-General Gambling Harm Scale (DGHS-7) | 7 |
| Measurement to assess risk, screen for psychiatric comorbidity, and inform referral | Suicidal ideation | Suicide risk item currently employed in NZ gambling harm services and recommended by MoH | 1 |
| Family/whānau violence | Hurt-Insulted-Threatened-Screamed (HITS) – single item adaptation for victimisation | 1 |
| Family/whānau violence | Hurt-Insulted-Threatened-Screamed (HITS) – single item adaptation for perpetration | 1 |
| Hazardous alcohol use | Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) | 3 |
| Other drug use | Single-Question Screening Test for Drug Use in Primary Care | 1 |
| Excessive gaming | Three-Item Gaming disorder Test-Online-Centred (TIGTOC) | 3 |

**OUTCOME MEASUREMENT – GAMBLER**

| **Domain** | **Construct** | **Measures** | **No. of items** |
| --- | --- | --- | --- |
| Measurement of the impact of treatment (gambling outcomes) | Gambling symptoms | Gambling Symptom Assessment Scale (G-SAS) | 12 |
| Gambling frequency | Global assessment items for online / land frequency  | 2 |
| Gambling expenditure | Global assessment items for online / land expenditure | 2 |
| Past treatment goal and achievement | Recovery Index for Gambling Disorder (RIGD) – Gambling Reduction subscale items | 2 |
| Future treatment goal and self-efficacy | Recovery Index for Gambling Disorder (RIGD) – Gambling Reduction subscale items | 2 |
| Measurement of the impact of treatment (non-gambling outcomes) | Depression symptoms | Patient Health Questionnaire-2 (PHQ-2) | 2 |
| Anxiety symptoms | Generalised Anxiety Disorder-2 (GAD-2) | 2 |
| Functional impairment | Work and Social Adjustment Scale (WSAS) | 5 |
| Wellbeing/quality of life | EUROHIS-QOL-8*Supplemented by Tangata Whaiora Questionnaire – Hua Oranga for cultural/spirituality reasons, where appropriate* | 8 |
| Measurement to inform treatment planning and assess processes of change | Readiness to change (readiness) | Readiness ruler (readiness) | 1 |
| Readiness to change (importance) | Readiness ruler (importance) | 1 |
| Readiness to change (confidence) | Readiness ruler (confidence | 1 |
| Gambling cognitions | Jonsson-Abbott Scale (JAS) – Gambling Fallacy subscale | 3 |
| Gambling urges | Gambling Symptom Assessment Scale (G-SAS) – Urge subscale | -\* |
| Measurement of client satisfaction | Client satisfaction | Client Satisfaction Questionnaire-4 (CSQ-4) | 4 |

\*Note the first four items of the Gambling Symptom Assessment Scale (G-SAS) can be used to measure gambling urges. If the G-SAS is not used for gambling symptoms then an alternative measure is needed for gambling urges.

## Recommended minimum dataset for affected others

|  |  |  |
| --- | --- | --- |
| Intake and screening - gambling | Number of items | 20 |
| Expected time | 3-4 Minutes |
| Repeated outcome monitoring – gambling | Number of items | 47 |
| Expected time | 8 minutes |

**INTAKE AND SCREENING – AFFECTED OTHER**

|  |  |  |  |
| --- | --- | --- | --- |
| **Domain** | **Construct** | **Measures** | **No. of items** |
| Description of affected others accessing the service | Relationship to the person who gambles | Pre-amble to the Gambling Harm Scale-10 for Affected Others (GHS-10-AO) | 2 |
| Gambling harms | The Gambling Harm Scale-10 for Affected Others (GHS-10-AO) | 10 |
| Measurement to assess risk, screen for psychiatric comorbidity, and inform referral | Suicidal ideation | Suicide risk item currently employed in NZ gambling harm services and recommended by MoH | 1 |
| Family/whānau violence | Hurt-Insulted-Threatened-Screamed (HITS) – single item adaptation for victimisation  | 1 |
| Family/whānau violence | Hurt-Insulted-Threatened-Screamed (HITS) – single item adaptation for perpetration | 1 |
| Hazardous alcohol use | Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) | 3 |
| Other drug use | Single-Question Screening Test for Drug Use in Primary Care | 1 |
| Own harmful gambling | One item screen | 1 |

**OUTCOME MEASUREMENT – AFFECTED OTHER**

| **Domain** | **Construct** | **Measures** | **No. of items** |
| --- | --- | --- | --- |
| Measurement of the impact of treatment (affected other focused) | Depression symptoms | Patient Health Questionnaire-2 (PHQ-2) | 2 |
| Anxiety symptoms | Generalised Anxiety Disorder-2 (GAD-2) | 2 |
| Stress symptoms | Perceived Stress Scale-4 (PSS-4) | 4 |
| Functional impairment | Work and Social Adjustment Scale (WSAS) | 5 |
| Wellbeing/quality of life | EUROHIS-QOL-8*Supplemented by Tangata Whaiora Questionnaire – Hua Oranga for cultural/spirituality reasons, where appropriate* | 8 |
| Measurement of the impact of treatment (gambler focused) | Gambling support self-efficacy | Caregiving Self-Efficacy Scale-8 (CSES-8) | 8 |
| Measurement to inform treatment planning and assess processes of change | Coping (active coping) | Brief-COPE – Adaptive (Active Coping subscale) | 2 |
| Coping (planning coping) | Brief-COPE – Adaptive (Planning Coping subscale) | 2 |
| Coping (self-blame) | Brief-COPE – Maladaptive (Self-Blame subscale) | 2 |
| Coping (behavioural disengagement) | Brief COPE – Maladaptive (Behavioural Disengagement subscale) | 2 |
| Social support (tangible support) | Brief Social Support Scale (BS6) (Tangible Support subscale) | 3 |
| Social support (emotional-informational support) | Brief Social Support Scale (BS6) (Emotional-Informational Support subscale) | 3 |
| Measurement of client satisfaction | Client satisfaction | Client Satisfaction Questionnaire-4 (CSQ-4) | 4 |

# Service delivery mapping

## Purpose of this section

The purpose of this section is to map the gambling screening tools currently being used or recommended in New Zealand services. This exercise outlines the tools applied to assess gambling harm, co-existing issues, and related outcomes for individuals and affected others. The mapping focused on identifying the tools, their scope, and their recommended use within the framework of Ministry of Health guidelines and service protocols.

## What we found

***Screens for people who gamble***

The Problem Gambling Severity Index (PGSI) was the primary screening tool used to assess problem gambling severity and has been renamed as a gambling harm scale. The PGSI was also been adapted for follow up evaluation so that each item is “since we last talked…” rather than its intended form as past 12 months. Regular follow-up assessments are a key component of the screening process. These assessments typically occur one month, three months, and six months after the initial intervention.

Other measures of gambling behaviours used in the sector include:

* Perceived control over gambling (single item)
* Amount of money lost collected as ‘dollars lost’ in the past month (exclude winnings) (single item)
* Annual household income (single item)

Brief interventions do not apply the PGSI and instead ask:

* One item question “Do you feel you have ever had a problem with gambling?

Then if a yes response, then the lie/bet two item questionnaire is delivered:

* Have you ever felt the need to bet more and more money?
* Have you ever had to lie to people about how much you gambled?

Further assessments of gambling behaviour may capture the following: Onset of gambling, frequency and duration, financial impact, periods of non-gambling, triggers and motivation and family and affected others

***Screens for affected others / whanau***

* The affected other screen comes from the Concerned Others Gambling Screen – which is not a validated tool. The same questions are asked in brief and full screening.
* One item *Do you think you have ever been affected by someone else’s gambling?*
	+ Scoring options 0-no to 3 yes that’s happening to me now. If no then no further screening.
* How would you describe the effect of that person’s gambling on you now?
	+ Agencies record the total number of positive responses for five ways that it could impact.

Assessment tools for family or affected others assess the impact of another person’s gambling on their lives. Assessment may include:

* Gambler’s gambling frequency over the past three months (four item options)
* Coping with the gamblers gambling: *Which of these three statements is true about your ability to cope with the person’s gambling over the last three months?* Scored as coping better, about the same or worse.

***Screens for co-existing issues***

Co-existing issues are part of a comprehensive assessment for all clients who are in a full intervention episode. The same constructs and screens are administered for affected others as the person who gambles.

Services may use a range of tools to assess co-existing issues that may influence or interact with gambling harm. These include:

* Alcohol use screened with the three item AUDIT-C.
* Drug use screened with the single item: *In the past 12 months, have you ever felt the need to cut down on your use of prescription or other drugs?*
* Depression: screened with the PHQ-2: *In the past 12 months, have you often felt down, depressed or hopeless? In the past 12 months, have you often had little interest or pleasure in doing things?*
	+ Scoring is yes/no and past 12 months which probably should be 0-3 and past 2 weeks
* Family/whānau concerns: Item from the HLS: *In the past 12 months, has anyone in your family/whānau worried about your health or wellbeing (including spiritual health)?*
	+ Scored No/yes
* Suicidality: *Within the last 12 months: Have you had thoughts of self-harm or suicide?*
	+ Scored on a 4-point scale from no thoughts in the last 12 months to I have tried to harm myself.
* Family violence: HITS tool if there is an indication of violence.
* Other items that may be included are nicotine use, anxiety and exercise patterns.

***Hua Oranga Outcome measure***

The Hua Oranga Outcome Measure provides a culturally informed framework for assessing wellbeing. It includes three separate schedules:

* Tangata Whaiora Schedule: Completed by the person seeking wellness.
* Whānau Schedule: Completed by a supportive family or whānau member.
* Pouāwhina Schedule: Completed by a practitioner providing treatment and care.

This measure assesses wellbeing across physical, spiritual, social, and emotional domains, reflecting a holistic approach to health and wellness.

## Summary

This mapping exercise identified the key screening tools currently in use or recommended for gambling harm interventions in New Zealand. It highlights the tools applied to assess gambling behaviour, co-existing issues, and family impacts, as well as the frameworks recommended for ongoing monitoring and culturally appropriate care.

# Clinician perspectives on treatment in New Zealand

## Purpose of this Section

This section provides a summary on mapping New Zealand service delivery and assessment practices for people experiencing gambling harm and their affected others in New Zealand (see Appendix 5 for the full report). The mapping involved a secondary analysis of data collected from New Zealand services during prior research conducted by Professor Dowling’s team at Deakin University. The analysis identified the types of assessments, treatment approaches, and specific strategies employed by clinicians and services. The intended outcome of this mapping was to guide the selection of outcome measures for people experiencing gambling harm.

## Methodology

In June to December 2022, a two-round Delphi study of Australian and New Zealand clinicians was conducted by Deakin University to identify clinician perspectives on the most effective gambling treatments and techniques. Both surveys were administered online, and participants were provided with a $100 e-gift voucher as reimbursement for their time and effort. This study was approved by Deakin University’s Human Research Ethics Committee (HeAG-H 11\_2021). This project provided important information, not only regarding clinician views on the effectiveness of gambling treatment and techniques, but also the training, use, confidence, and competency levels of gambling clinicians.

In this report, we only present the descriptive information from the 14 New Zealand clinicians participating in the research. Of these participating clinicians, 10 completed both Rounds 1 and 2, 3 completed only Round 1, and one partially completed both Rounds 1 and 2. New Zealand clinicians were recruited from PGF Services, the Salvation Army, and Asian Family Services. The service providers were a clinically experienced sample, with the majority reporting over five years working clinically (71%) and working clinically with people with gambling problems (50%).

## What we found

Key findings

* All clinicians used CBT and MI and these treatments had the highest proportions of use.
* Most clinicians were fairly or very confident in using CBT and MI, followed by psychoeducation and mindfulness-based cognitive therapy/stress reduction.
* All clinicians reported that cognitive restructuring and goal setting are effective techniques, while nearly all clinicians believed that relapse prevention, information gathering, information provision, financial management, and planning social support are effective techniques. In contrast, few clinicians thought that imaginal desensitisation, exposure, and social comparison were effective techniques.
* All clinicians used goal setting, relapse prevention, information provision, motivational enhancement, and behaviour substitution with more than half or all/almost all of their clients; and nearly all clinicians used information gathering with more than half or all/almost all of their clients. In contrast, few clinicians used imaginal desensitisation, exposure, or social comparison with more than half or all/almost all of their clients.
* All clinicians were fairly or very confident in using goal setting, information provision, planning social support, problem solving, and self-monitoring; and nearly all clinicians were fairly or very confident in using relapse prevention, information gathering, motivational enhancement, behaviour substitution, and feedback on assessment. In contrast, few clinicians were this confident in using imaginal desensitisation, exposure, and social comparison.
* Prolonged practitioner-delivered interventions were perceived as being more effective than brief practitioner-delivered interventions.
* About half agreed that abstinence goals are more effective than non-abstinence goals but that interventions with non-abstinence goals are better than no intervention.
* For people with psychiatric comorbidities, both genders (men, women), age (young people, seniors), and gambling activities (electronic gaming machines [EGMs] and gambling other than EGMs), most clinicians agreed or strongly agreed that psychological interventions are more effective than no intervention but few agreed that they were better than any other intervention.
* In terms of sequencing for psychiatric comorbidities, few clinicians agreed that sequenced interventions are more effective than simultaneous interventions or that interventions with gambling treated first are more effective than interventions with comorbidities treated first.

## Summary

The findings indicate that Cognitive Behavioural Therapy (CBT) and Motivational Interviewing (MI) are the most commonly used approaches among clinicians, with high levels of confidence and skill reported in implementing these therapies.

Motivational Interviewing focuses on enhancing readiness for change (including self-efficacy or confidence in their ability to change), suggesting that outcome measures should assess shifts in these constructs over time. Similarly, setting treatment goals such as abstinence or reduction in gambling requires tracking progress in achieving these goals, including reductions in gambling expenditure and frequency.

CBT addresses key constructs such as gambling urges, maladaptive cognitions, and the broader harms of gambling, including functional impairments and overall life disruption. Clinicians consistently reported confidence in techniques like cognitive restructuring, relapse prevention, and planning social support, highlighting the need to monitor improvements in these areas to evaluate the effectiveness of interventions.

There is also a clear recognition of the importance of tailoring interventions for specific populations, particularly those with psychiatric comorbidities. This underscores the need for screening tools to identify co-occurring addictions, alongside treatment outcomes that monitor changes in depression, anxiety, and quality of life.

# Measurement recommendation considerations

## Purpose of this section

This document provides recommendations for outcome measurement in gambling harm treatment services in New Zealand. It aims to serve as a practical resource for the Ministry of Health in identifying appropriate measures for a "minimum dataset" tailored to these services.

The evidence presented in this report suggests that clinicians in these services predominantly employ Cognitive Behavioural Therapy (CBT) and Motivational Interviewing (MI), which are currently best practice in gambling treatments. Measures were therefore selected with reference to the specific processes (or mechanisms of change) targeted in these interventions.

This section provides a brief overview of the purpose of screening and assessment followed by a high-level consideration for measurement selection. This section then presents the methods to identify appropriate therapeutic constructs and measures with reference to those already employed in the New Zealand gambling harm services, but that would also be acceptable in terms of reliability, validity, classification accuracy, sensitivity to change, cultural suitability, self-administration, brevity, and availability.

## Purpose of screening and assessment

In psychological therapies, screening and assessment are distinct but interconnected processes that serve critical purposes in understanding and addressing a client’s mental health needs. Both processes are integral to delivering effective psychological care and ensuring that clients receive the most appropriate interventions.

Screening can be used to assess risk, determine if a client may have psychological issues that warrant further assessment, and whether referral to other services is needed. Screening tools, which are often brief and standardised, are usually focused on identifying the presence of symptoms rather than providing a comprehensive diagnosis.

* *Risk assessment*: Screening can be used to highlight urgent issues that require immediate intervention, such as suicidal ideation or severe distress.
* *Further assessment*: A positive screen can determine if further assessment is warranted.
* *Referral*: Screening can be used to assess whether referral to another professional or service is needed. The first aim of the current project was to identify screening tools that could be used to identify gambling and other issues that may warrant further assessment.

In contrast, the purpose of assessment is to gather detailed information about the client’s psychological, emotional, and social functioning. Assessment is usually more in-depth, multi-faceted (e.g., interviews, behavioural observations, psychometric testing), and may include input from multiple sources. Specifically, it can facilitate an understanding of the client’s presenting problems, facilitate treatment planning and monitoring progress, including the mechanisms of change.

* *Presenting problems or diagnosis*: Identifying the client’s main concerns or symptoms, contributing causes (such as biological, psychological, or social influences), strengths and resources, and diagnosis, if appropriate.
* *Treatment planning and processes of change*: Developing tailored treatment plans and goals to address the client’s unique needs and circumstances.
* *Monitoring progress*: Evaluating effectiveness of the intervention over time. These include the intended client outcomes, which may be gambling-related (e.g., gambling symptoms) or non-gambling-related (e.g., depression or quality of life). To be effective these measures should reflect the aims of interventions employed in treatment services – such as gambling symptoms or behaviour. Such assessment should also measure changes in the therapeutic targets of the intervention (sometimes called the processes of change). For example, CBT may target gambling-related cognitions so there would be an expectation that these cognitions would be reduced over time. Similarly, MI may target readiness to change or self-efficacy so these constructs should be measured over time.

## Minimum dataset considerations

The primary objective of this document is to review and identify gambling-related measures suitable for assessing outcomes in treatment services. It seeks to recommend instruments for inclusion in a "minimum dataset" that are specifically tailored for use in New Zealand gambling harm services. This recommendation is informed by document reviews and secondary data analyses.

The development of the minimum dataset was guided by several considerations to ensure practicality and relevance for gambling harm treatment services in New Zealand. The first consideration was brevity. The combined dataset should take no longer than 15 minutes to administer in order to minimise client burden while ensuring usability for service providers. This brevity ensures that the tools are both efficient and effective in clinical and research settings.

Another key consideration was the selection of constructs. Constructs were selected based on their relevance to gambling harm treatment, focusing on outcomes that align with contemporary treatment practices. For example, psychological distress is considered essential to measure as it reflects a primary focus of many service providers. However, constructs such as alcohol and drug use, which are not commonly targeted in most gambling harm treatment, were excluded. Moreover, we made a deliberate effort for the dataset to emphasise recovery and wellness, moving beyond deficit-focused measures like psychological distress to include constructs such as wellbeing and quality of life.

The selection of measures also accounted for mechanisms of change targeted by the predominant treatment approaches in New Zealand—specifically, CBT and MI. Recommended measures reflect processes and mechanisms of change central to these evidence-based approaches. While the focus remains on outcomes, some process-oriented constructs relevant to CBT and MI, such as treatment planning, have also been included. For clinicians employing third-wave interventions, additional measures assessing constructs like mindfulness or acceptance may be appropriate and are encouraged for tailored treatment planning.

The selection of screening measures considered current practice as well as considerable research evidence that people experiencing gambling harm also experience a range of psychological problems. These problems, which often go undetected, are likely to influence the effectiveness of gambling treatment services and may warrant referral to other services. Evidence suggests that the most highly comorbid psychological problems include depression, anxiety, and alcohol or other drug use problems.

Finally, applicability to all clients was another important consideration in the selection process. The measures recommended in the dataset are designed to be socially and culturally appropriate for all clients, ensuring inclusivity and relevance. Constructs that were not universally applicable, such as family functioning or relationship satisfaction, were excluded to maintain this focus.

## Measure selection criteria

Measures were identified through a rapid review of the research literature and the reference lists of relevant recent articles and literature reviews. Articles detailing psychometric properties, such as reliability, validity, classification accuracy, and sensitivity to change, formed the basis of the review. The measures included in the recommended minimum dataset were evaluated against several key criteria:

1. *Measures are in current use in New Zealand services*. Measures currently employed in New Zealand gambling harm services, as identified through a document review, were prioritised.
2. *Measures have good reliability*. Reliability refers to the consistency of a measure across different contexts or raters and includes the following:
* Internal Consistency: Ensures that items within a measure strongly correlate with one another when assessing the same construct.
* Test-Retest Reliability: Evaluates the stability of scores over time, with stronger associations indicating higher reliability.
* Inter-Rater Reliability: Assesses the agreement between different trained raters or observers.
1. *Measures have good validity*. Validity assesses how well a measure evaluates the intended construct in relation to external criteria and includes the following:
* Content Validity: Ensures the measure comprehensively covers all aspects of the construct.
* Construct Validity: Ensures the measure focuses solely on the intended construct.
* Convergent Validity: High correlation with other measures of the same construct.
* Discriminant Validity: Low correlation with measures of unrelated constructs.
* Criterion Validity: Assesses alignment with a gold-standard measure.
* Concurrent Validity: Strong correlation with another current measure of the same construct.
* Predictive Validity: Accuracy in predicting future behaviours or outcomes.
1. *Measures have good classification (diagnostic) accuracy*. This measures the ability to correctly identify a condition and includes the following:
* Sensitivity: Accuracy in identifying those with the condition.
* Specificity: Accuracy in identifying those without the condition.
1. *Measures are sensitive to change*. This refers to the ability of a measure to detect meaningful changes in a client’s condition over time, particularly following interventions. Measures with short-term timeframes were prioritised to capture rapid changes resulting from gambling interventions.
2. *Measures had cultural suitability*. Measures were selected for cultural appropriateness, especially for New Zealand populations. Those already in use by New Zealand gambling harm services were prioritised.
3. *Measures could be administered by self-report*. Although self-report measures may risk under-reporting due to social desirability, research indicates they generally provide valid and reliable data.
	* Measures were selected based on ease of administration, confidentiality assurances, and clarity of wording.
	* Clinical interviews, neurocognitive tests, or clinician-administered tools were excluded due to practical constraints, though they may still play a role in detailed client assessments.
4. *Measures must be brief*.
* Outcome Measures: Instruments with 15 items or fewer were selected to describe client characteristics, measure treatment impact, plan interventions, and assess satisfaction.
* Screening Measures: Even shorter instruments (5 items or fewer) were identified for risk assessment, screening for psychiatric comorbidities, and informing referrals.
1. *Measures should be freely available*. Only publicly available measures (free of copyright restrictions) were included to ensure accessibility for widespread use.

## Literature search

A literature search was conducted using key terms such as "gambling," "measurement," "systematic review," "meta-analysis," and "consensus guidelines." This search identified twelve research articles on gambling screening and outcome measurement,1-12 as well as three reviews focused on affected others.13-15 Nine criteria were developed for selecting measures for the "minimum dataset." These included demonstrating strong psychometric properties (reliability, validity, and sensitivity to change), being brief and easy to administer, minimising burden on clients and clinicians, and aligning with the focus of gambling harm treatment services in New Zealand, emphasising recovery, wellness, and evidence-based approaches like CBT and MI.

Over 80 measures were extracted from the review studies and assessed against these criteria. Measures with poor psychometric properties, excessive length (more than five items for intake/screening or more than fifteen items for treatment outcomes), or misaligned constructs were excluded. About 30% of measures were rejected based on length alone. Those meeting the criteria were included in a long list for further evaluation. The following section details the selection process and provides a description of each of the recommended measures.

# Measurement recommendations and rationale – Gambling

This section outlines the recommended measures for screening and assessment for people who gamble in gambling harm treatment services in New Zealand. Each section provides an explanation and rationale for the construct and recommended measure. Tables are included to present the recommended constructs and measures, along with concise justifications. Each recommended measure is described in detail, including its purpose, the domains it assesses, and its administration and scoring protocols. This includes the number of items, response options, and scoring methods. In Appendix 6 is a table that summarises the constructs, acceptable measures, recommended measures for each construct, and whether they are included in the minimum dataset.

## Measurement to describe people who gamble and are accessing the service

Most minimum datasets measure gambling characteristics prior to treatment to describe the clients accessing the service. These characteristics, which would only be measured at the start of treatment include the activities on which clients experience harms, the modality of gambling, and gambling harms. In this category, only no-cost self-report measures with 15 or fewer items are included. In the recommended minimum dataset, only the construct of gambling harms is measured using a standardised measure (see Appendix 1 for full screens).

**Gambling harm**. Gambling harm refers to any initial or exacerbated adverse consequence due to an engagement with gambling that leads to a decrement to the health or wellbeing of an individual, family unit, community of population. Gambling harm is an overlapping, but distinct, construct relative to problem gambling, whereby problem gambling is characterised by both symptoms of behavioural dependence (e.g., tolerance, loss of control, persistent use despite negative consequences, withdrawal symptoms, and mood modification) and adverse consequences or harms. Gambling harm is not an appropriate measure as an outcome of treatment as gambling harms can lag behind changes in gambling behaviour and can persist well after gambling behaviour has been resolved.

We selected the Domain-General Gambling Harm Scale (DGHS-7) to measure gambling harms. Although the Gambling Harms Scale-10 (GHS-10) (formerly Short Gambling Harms Scale) is the most widely validated and employed measure of gambling harm internationally and in New Zealand, it has been criticised on the grounds of poor face validity (e.g., the items do not provide coverage of all of the domains of gambling harm). In contrast, the DGHS-7 includes one item for measuring all harm domains: financial, emotional, relationship, health, work/study, cultural, criminal. It is a brief measure that demonstrates robust reliability and validity.

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| --- | --- | --- | --- |
| **Construct** | **Measure** | **Description** | **Administration and scoring** |
| Gambling harms | Domain-General Gambling Harm Scale (DGHS-&) | **Purpose**: To provide a general and short measure covering all recognised domains of gambling harm**Timeframe**: Past 12 months**Domains**: None (although each item represents a distinct domain of harm) | **Number of items**: 7**Response options**: 5-point scale from (0) no impact to (4) major impact**Scoring**: Add to obtain total score; higher scores indicate greater harm; scores range from 0-28; no cut-off score |

## Measurement to assess risk, screen for psychiatric comorbidity, and inform referral

Measurement of treatment outcomes for gambling is optimal when measurement assess risk, screens for psychiatric comorbidity, and informs referral to other services or agencies. In the minimum dataset, these are only routinely administered prior to treatment, but clinicians may choose to screen at other times during treatment to inform their practice. These tools are not diagnostic so in the event that clients screen positive on these brief measures, more detailed assessment or referral to other services may be required. In this category, only no-cost self-report measures with 5 or fewer items are included. In the minimum dataset, we recommend screening for suicidal ideation, family/ whānau violence, hazardous alcohol use, other drug use, gaming, depression, and anxiety as these issues are highly comorbid with gambling issues and can influence treatment engagement and outcomes. Note that the depression and anxiety measures are also suggested treatment outcomes so are described later in this section.

**Suicidal ideation**. We selected the suicide risk item currently employed in the New Zealand gambling harm services and that has been recommended by the Ministry of Health. There are few brief screening items available in the literature and many organisations employ their own bespoke items. We consider the item currently in use fit-for-purpose.

| **Construct** | **Measure** | **Description** | **Administration and scoring** |
| --- | --- | --- | --- |
| Suicidal ideation | Suicide risk item currently employed in NZ gambling harm services and recommended by MoH | **Purpose**: to provide a single-item measuring thoughts of self-harm or suicide**Timeframe:** Past 12 months**Domains**: None | **Number of items**: 1**Response options**: 4-point scale from (0) no thoughts to (3) tried to harm myself**Scoring**: Scores can range from 0 to 3; higher scores indicate greater suicidal ideation; no cut-off |

**Family/whānau violence**. We selected a modified version of the Hurt, Insult, Threaten, and Scream (HITS) to measure family/whānau violence. This measure has a relatively broad coverage of family/whānau violence, although sexual abuse, coercive control, and financial abuse are not measured. However, none of the available brief screens measure all aspects of family violence. Moreover, this screen lends itself to measuring perpetration, as well as victimisation, both of which are highly associated with gambling issues. This measure is currently being employed in the New Zealand gambling harm services and has been employed in family violence research funded by the Ministry of Health.

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| --- | --- | --- | --- |
| **Construct** | **Measure** | **Description** | **Administration and scoring** |
| Family/whānau violence | Hurt-Insulted-Threatened-Screamed (HITS) – single item adaptations for victimisation and perpetration  | **Purpose**: to provide very brief screens for family/whānau violence victimisation and perpetration**Timeframe:** Past 12 months**Domains**: Victimisation, perpetration | **Number of items**: 2**Response options**: 4-point scale from (1) never to (5) frequently. **Scoring**: Each item should be scored separately. Scores on each item can range from 1 to 5; higher scores indicate greater family/whānau violence; no cut-off |

**Hazardous alcohol use**. We selected the Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) to measure hazardous alcohol use. This measure is a short form of the 10-item AUDIT, which is the most commonly employed alcohol use measure internationally and in New Zealand. It is also the measure currently employed in the New Zealand gambling harm services. It has excellent reliability and validity, as well as good classification accuracy relative to the AUDIT and other gold-standard measures.

| **Construct** | **Measure** | **Description** | **Administration and scoring** |
| --- | --- | --- | --- |
| Hazardous alcohol use | Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) | **Purpose**: to provide a very brief screen for hazardous alcohol use**Timeframe:** Current**Domains**: None | **Number of items**: 3**Response options**: 5-point scale from 0-4, with varying response labels**Scoring**: Add to obtain total score; higher scores indicate greater alcohol use issues; scores range from 0-12; cut-off scores: men (≥4), women (≥3) |

**Other drug use**. We selected the Single-Question Screening Test for Drug Use in Primary Care to measure other drug use. This measure is extremely brief and provide a quick screen of both illegal drugs and prescription drug misuse. It has excellent reliability and validity and good classification accuracy relative to standardised diagnostic interviews.

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| --- | --- | --- | --- |
| **Construct** | **Measure** | **Description** | **Administration and scoring** |
| Other drug use | Single-Question Screening Test for Drug Use in Primary Care | **Purpose**: to provide a single-item screening test for drug use and drug use disorders in primary care**Timeframe:** Past 12-months**Domains**: None | **Number of items**: 1**Response options**: Open text field**Scoring**: Higher scores indicate more frequent drug use; cut-off score: ≥1 |

**Excessive gaming**. We selected the Three-Item Gaming disorder Test Online Centred (TIGTOC) to measure excessive internet gaming. This measure is the only brief standardised 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 from the International Classification of Diseases (ICD-11).

| **Construct** | **Measure** | **Description** | **Administration and scoring** |
| --- | --- | --- | --- |
| Excessive gaming | Three-Item Gaming disorder Test Online Centred (TIGTOC) | **Purpose**: to provide an ultra-brief screening tool for online gaming disorder**Timeframe:** Past 12-months**Domains**: None | **Number of items**: 3**Response options**: 4-point scale from (0) not at all to (3) always; additional (0) for no gaming in past 12-months**Scoring**: Add to obtain total score; higher scores indicate greater online gaming problems; scores range from 0-9; cut-off score: ≥4 |

## Measurement of the impact of treatment

Measurement of treatment outcomes for gambling is optimal when measurement reflects the aims and intention of treatment delivered. These tools may include gambling outcomes, such as gambling symptoms, non-gambling outcomes, such as depression, or recovery outcomes, such as wellbeing. In the minimum dataset, these measures are routinely administered at multiple set timepoints at post-treatment and follow-up time periods. In this category, only no-cost self-report items with 15 or fewer items are included (see Appendix 2 for full screens).

***Gambling outcomes***

In the minimum dataset, we recommend measuring gambling symptoms, gambling behaviour, and treatment goal attainment as treatment outcomes as these are the most relevant targets of the treatments delivered in the New Zealand gambling harm services.

**Gambling symptoms**. As indicated earlier, it is not appropriate to employ gambling harms as an outcome measure. Moreover, many of the “problem gambling” assessment instruments, such as the Problem Gambling Severity Index, are not appropriate treatment outcome measures as most were developed to determine prevalence of “problem” or “at-risk” gambling” in the general population and employ past-year timeframes. Moreover, the ability of measures such as the PGSI to adequately discriminate between gamblers attending gambling harm services is questionable given that almost all are classified in the problem gambling category. While the EIGHT screen, which is commonly employed as a “problem gambling” screening tool in New Zealand, could arguably be used as treatment outcome measure as it has a current timeframe, it was developed for the purpose of screening in primary care settings and there is no research establishing its sensitivity to change. Of the very few measures specifically designed to measure treatment outcomes, the Gambling Symptom Assessment Scale (G-SAS) has been the most commonly employed internationally. The G-SAS is not a diagnostic or screening instrument, but instead measures gambling symptoms over the past 7 days. There is evidence that the G-SAS is reliable and valid in assessing changes in symptoms during treatment.

| **Construct** | **Measure** | **Description** | **Administration and scoring** |
| --- | --- | --- | --- |
| Gambling symptoms | Gambling Symptom Assessment Scale (G-SAS) | **Purpose**: to assess gambling symptom severity and change during treatment**Timeframe:** Past 7-days**Domains**: None (but the first four items can be used to assess change in urge symptoms) | **Number of items**: 12**Response options**: 5-point scale from 0-4, with varying response labels**Scoring**: Add to obtain total score; higher scores indicate greater gambling symptoms; scores range from 0-48; cut-off scores: extreme (41-48), severe (31-40), moderate (21-30), mild (8-20), minimal (0-7) |

**Gambling behaviour**. Despite being commonly employed as treatment outcome measures, there are no standardised measures of gambling behaviour (frequency, expenditure, duration), with research and clinical services tending to employ their own bespoke versions of global assessment items. Although the Followback method has been used in research in New Zealand and is considered best practice, it requires training and takes considerable time to administer. Moreover, there is recent evidence that suggests that its accuracy for measuring gambling expenditure is no better than a single-item global measure. We therefore recommend global assessment items to measure gambling frequency and expenditure. In designing these bespoke items, we have taken several issues into consideration: (1) to separate out behaviour based on gambling modality; (2) to employ “number of days” for gambling frequency given it is now almost impossible for many people who gamble heavily online to determine how often they place a bet; and (3) to employ best-practice descriptions of gambling expenditure to ensure the elicitation of the most reliable expenditure data as possible.

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| **Construct** | **Measure** | **Description** | **Administration and scoring** |
| Gambling behaviour | Global assessment items | **Purpose**: to assess gambling frequency and expenditure and change during treatment**Timeframe:** Past 30-days**Domains**: Frequency, expenditure via venue and online | **Number of items**: 4**Response options**: Open text fields**Scoring**: Add modalities to obtain total frequency or expenditure; higher scores indicate greater frequency/expenditure; no cut-scores (although can compare to gambling lower-risk limits) |

**Treatment goal planning and achievement**. In New Zealand, the adoption of a harm minimisation perspective facilitates both abstinence and non-abstinence treatment goals. Indeed, there is evidence that a significant proportion of clients accessing services select non-abstinence goals, which can involve avoiding the specific type/s of gambling that cause the most harm and continuing to gamble on any type of gambling but at an affordable level. It is important, however, to note that treatment goals and their achievement can change over time, so it is important that these are measured at multiple timepoints. We believe the Gambling Reduction subscale of the Recovery Index for Gambling (RIGD) effectively facilitates the setting of future treatment goals, alongside client self-efficacy to achieve these goals, as well as the achievement of past treatment goals. This subscale has demonstrated good reliability and validity

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| **Construct** | **Measure** | **Description** | **Administration and scoring** |
| Treatment goal planning and achievement | Recovery Index for Gambling Disorder (RIGD) - Gambling Reduction subscale | **Purpose**: to assess treatment goal achievement and facilitate treatment goal planning**Timeframe**: Past 4-weeks**Domains**: Treatment goal planning and achievement | **Number of items**: 4**Response options**: 3 treatment goals, with achievement and self-efficacy rated on varying 5-point scales**Scoring**: Past-goal achievement from (1) not at all to (5) completely; future goal self-efficacy from (1) not at all to (5) very confident |

***Non-gambling outcomes***

In the minimum dataset, we recommend measuring depression symptoms, anxiety symptoms, functional impairment, and wellbeing/quality of life as treatment outcomes as these are the most relevant targets of the treatments delivered in the New Zealand gambling harm services.

**Depression symptoms**. There is a general expectation that psychological distress, which is comprised of both depression and anxiety symptoms, is a target of face-to-face services. We decided to measure depression and anxiety symptoms separately, rather than employ a composite measure, such as the Kessler-6, to facilitate interpretation by clinicians. Given that depression is highly comorbid with gambling issues, we propose that depression symptoms are measured to both determine the presence of a psychiatric comorbidity that may require referral to mental health services, as well as to determine treatment outcomes. We selected the Patient Health Questionnaire-2 (PHQ-2) because it is an extremely commonly used and very brief measure assessing the frequency of depressed mood and anhedonia, which are the two core features of depressive disorders. The PHQ-2 demonstrates very good reliability, validity, classification accuracy relative to gold-standard diagnosis, and sensitivity to change.

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| **Construct** | **Measure** | **Description** | **Administration and scoring** |
| Depression symptoms | Patient Health Questionnaire-2 (PHQ-2) | **Purpose**: to assess the presence and frequency of major depression symptoms**Timeframe**: Past 2-weeks**Domains**: None | **Number of items**: 2**Response options**: 4-point scale from (0) not at all to (3) nearly every day**Scoring**: Add to obtain total score; higher scores indicate greater depression symptoms; scores range from 0-6; cut-off scores: ≥3 indicates positive screen for major depression |

**Anxiety symptoms**. Similarly, given that anxiety is highly comorbid with gambling issues, we propose that anxiety symptoms are measured to both determine the presence of a psychiatric comorbidity that may require referral to mental health services, as well as to determine treatment outcomes. We selected the Generalised Anxiety Disorder-2 (GAD-2) because it is an extremely commonly used and very brief measure assessing nervousness and an inability to control worry, which are two core features of generalised anxiety disorder. The GAD-2 demonstrates very good reliability, validity, classification accuracy relative to gold standard diagnosis, and sensitivity to change.

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| **Construct** | **Measure** | **Description** | **Administration and scoring** |
| Anxiety symptoms | Generalised Anxiety Disorder (GAD-2) | **Purpose**: to assess the frequency of generalised anxiety symptoms**Timeframe**: Past 2-weeks**Domains**: None | **Number of items**: 2**Response options**: 4-point scale from (0) not at all to (3) nearly every day**Scoring**: Add to obtain total score; higher scores indicate greater anxiety symptoms; scores range from 0-6; cut-off scores: ≥3 indicates positive screen for generalised anxiety disorder |

**Functional impairment**. Functional impairment is increasingly employed as a treatment outcome measure in gambling treatment. Functional impairment refers to how the disruptions or limitations in an individual’s ability to perform everyday activities and role due to their gambling. In contrast, harm refers to the negative consequences directly or indirectly caused by gambling. While there are several commonly employed measures of functional impairment, they tend to comprise too many items, be focused on physical health functioning, or be available only through a licence. For this reason, we selected the Work and Social Adjustment Scale (modified for gambling) for inclusion in the minimal dataset. The WSAS is a simple and reliable measure that assesses the impact of a person’s gambling on their ability to function in terms of work, home management, social leisure, private leisure, and personal or family relationships. It has demonstrated good reliability, validity, classification accuracy, and sensitivity to change.

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| **Construct** | **Measure** | **Description** | **Administration and scoring** |
| Functional impairment | Work and Social Adjustment Scale (WSAS) | **Purpose**: to provide a brief and simple measure for impairment in functioning as a result of gambling**Timeframe**: Current**Domains**: None | **Number of items**: 5**Response options**: 9-point scale from (0) not at all to (8) very severely**Scoring**: Add to obtain total score; higher scores indicate more functional impairment; scores range from 0-40; cut-off scores: moderately severe (21-40), significant functional impairment (10-20), subclinical impairment (0-9) |

**Wellbeing/quality of life**. Recovery, as a general term, has undergone a recent transformation of meaning. There is increasing recognition that recovery defined only as the absence or remission of symptoms and a return to a former state of functioning is insufficient. For example, the World Health Organisation (WHO) emphasises a broad and holistic understanding of recovery as a dynamic and individualised process aimed at achieving optimal health, functioning, and wellbeing. We therefore selected the EUROHIS-QOL-8 to measure wellbeing/quality of life as it is the briefest version of the internationally recognised WHO’s quality of life instruments, designed to provide a concise assessment of overall quality of life across diverse populations. It has demonstrated good cross-cultural performance, reliability, validity, and sensitivity to change.

Note: We acknowledge the cultural appropriateness of the Tangata Whaiora Questionnaire – Hua Oranga. Due to other considerations, such as the length [16 items] and the lack of available psychometric information, we feel that this should be included as a supplementary measure, if deemed appropriate by a given service.

| **Construct** | **Measure** | **Description** | **Administration and scoring** |
| --- | --- | --- | --- |
| Wellbeing/quality of life | EUROHIS-QOL-8*Supplemented by**Tangata Whaiora Questionnaire – Hua Oranga for cultural/spirituality reasons, where appropriate* | **Purpose**: to assess overall quality of life across diverse populations**Timeframe**: Past 2-weeks**Domains**: Physical health, psychological wellbeing, social relationships, environmental factors | **Number of items**: 8**Response options**: 5-point scale from (1) very poor to (5) very good**Scoring**: Add to obtain total score; higher scores indicate more positive quality of life; scores range from 8-40; no cut-off scores |

## Measurement to inform treatment planning and assess processes of change

Measurement of treatment outcomes for gambling is optimal when measurement reflects the constructs that are targeted by treatment. These measures can be used to facilitate treatment planning or be examined as the mechanisms or processes of change, which are the underlying factors through which a treatment exerts it’s effects and leads to desired outcomes. At a very simple level, these measures can be viewed as secondary outcome measures because they are targeted in CBT (e.g., gambling cognitions) and MI (e.g., readiness to change, importance of change, and confidence of change), which are the predominant therapeutic modalities employed by clinicians in the New Zealand gambling harm services. In the minimum dataset, we have selected to measure readiness to change, gambling cognitions, and gambling urges as these are the most commonly employed mechanisms targeted in CBT and MI interventions by the clinicians. There are, of course, other constructs that can facilitate treatment planning or serve as processes of change, such as coping, social support, anger, self-esteem, stressful life events, emotion dysregulation, distress tolerance, mindfulness, acceptance, social skills, dysfunctional thinking, and problem solving but these were deemed outside of the scope of this report. In the minimum dataset, these measures are routinely administered at multiple set timepoints at post-treatment and follow-up time periods. In this category, only no-cost self-report items with 15 or fewer items are included.

**Readiness to change**. Importantly, gambling treatments should aim to enhance readiness to change (how ready clients feel to take action), importance of change (how important the change is to them), and confidence to change (how confident they feel about making the change). Readiness rulers are visual or numerical tools to assess these aspects of readiness to change a specific behaviour that are commonly employed in MI and other behaviour change interventions to facilitate discussions about motivation and commitment. The rulers are often referred to as “Ready, Willing, and Able” to reflect readiness, importance, and confidence, respectively. While there are much longer measures of readiness, such as the Gambling Readiness to Change Questionnaire (GRTC), and confidence, such as the Brief Situational Confidence Questionnaire (BSCQ), the rulers provide a simple and intuitive way of measuring these facets of readiness that can be revisited throughout the intervention to track changes over time. They can be used to identify ambivalence or barriers to change, tailor intervention strategies to the client’s current stage of change, and foster collaborative, nonjudgemental discussions about behaviour change.

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| --- | --- | --- | --- |
| **Construct** | **Measure** | **Description** | **Administration and scoring** |
| Readiness to change | Readiness rulers | **Purpose**: to provide a simple and intuitive measure of readiness to change that can encourage conversation and be readministered throughout the intervention to track changes over time**Timeframe**: Current**Domains**: Readiness (Ready), Importance (Willing), and Confidence (Able) | **Number of items**: 3**Response options**: 9-point scale from (1) not at all to (10) totally/highest**Scoring**: Each item should be scored separately; higher scores indicate more readiness to change; no cut-off scores |

**Gambling cognitions**. CBT treatments should aim to reduce gambling-related cognitions using cognitive restructuring techniques. While gambling cognitions are often measured as outcomes in psychological gambling treatments, most of the available measures are prohibitively long. The only very brief measure of gambling is the 3-item Gambling Fallacy subscale of the Jonsson Abbott Scale (JAS). This scale, which was employed in the Swedish Longitudinal Gambling Study (Swelogs) demonstrates good reliability and validity.

| **Construct** | **Measure** | **Description** | **Administration and scoring** |
| --- | --- | --- | --- |
| **Gambling cognitions** | Jonsson Abbott (JAS) - Gambling Fallacy subscale  | **Purpose**: to measure misconceptions about gambling**Timeframe**: Current**Domains**: None | **Number of items**: 3**Response options**: 7-point scale from (1) do not agree at all to (7) agree completely **Scoring**: Add to obtain total score; scores range from 7 to 21; higher scores indicate higher misconceptions; no cut-off scores |

## Measurement of client satisfaction

At post-treatment and follow-up timepoints, it is important to assess client satisfaction with the service provided. Measuring client satisfaction with treatment helps assess the effectiveness and quality of the intervention from the client’s perspective, providing valuable feedback for improvement. It can also enhance engagement and retention, ensuring that the treatment aligns with the clients' needs and expectations. Although there are a range of client satisfaction measures available, we selected the Client Satisfaction Questionnaire-4 (CSQ-4) as it is a frequently cited brief measure with great face validity. This scale has demonstrated good reliability, validity, and sensitivity to change.

|  |  |  |  |
| --- | --- | --- | --- |
| **Construct** | **Measure** | **Description** | **Administration and scoring** |
| Client satisfaction | Client Satisfaction Questionnaire-4 (CSQ-4) | **Purpose**: to assess consumer satisfaction with health and human services**Timeframe**: Current**Domains**: None | **Number of items**: 4**Response options**: 4-point scale, from 1-4, with varying response options**Scoring**: Add to obtain total score; scores range from 4 to 16, higher scores indicate higher treatment satisfaction; no cut-off scores |

# Measurement recommendations and rationale - Affected others

This section outlines the recommended measures for screening and assessment for people who gamble in gambling harm treatment services in New Zealand. Each section provides an explanation and rationale for the construct and recommended measure. Tables are included to present the recommended constructs and measures, along with concise justifications. Each recommended measure is described in detail, including its purpose, the domains it assesses, and its administration and scoring protocols. This includes the number of items, response options, and scoring methods. In Appendix 7 is a table that summarises the constructs, acceptable measures, recommended measures for each construct, and whether they are included in the minimum dataset.

## Description of affected others accessing the service

In addition to socio-demographic information, helpful descriptive information collected for affected others includes identifying the family member/friend(s) whose gambling has resulted in harm, as well as the harms experienced by affected others as a result of the gambling. For this reason, we have combined an item measuring the identification of the gambling family member/friend(s) with the new Gambling Harm Scale-10 for Affected Others (GHS-10-AO). In this category, measures only need to be measured at the start of treatment and only no-cost self-report measures with 15 or fewer items are included (see Appendix 3 for full screens).

**Gambling harms.** We selected the GHS-10-AO to measure gambling harms reported by affected others. Although this is a new measure, it was developed as a complement to Gambling Harm Scale-10 (GHO-10), formerly known as the Short Gambling Harms Scale, and the Domain-General Gambling Harm Scale (DGHS-7). It is a brief measure that provides good coverage of the domains of harm, including psychological and emotional distress, time reallocation from other life commitments, relationship stress, and financial impacts. This scale has also received the most empirical validation, including benchmarking to health utility, with good reliability and concordance with its 20-item counterpart.

| **Construct** | **Measure** | **Description** | **Administration and scoring** |
| --- | --- | --- | --- |
| Gambling harms | Gambling Harm Scale-10 for Affected Others (GHS-10-AO) | **Purpose**: To complement the existing harm scale for people who gamble using similar methodologies **Timeframe**: Past 12 months **Domains**: None | **Number of items**: 10 **Response options**: Binary scale (no, yes) **Scoring**: Add to obtain total score; higher scores indicate greater harm; scores range from 0-10; no cut-off score |

## Measurement to assess risk, screen for psychiatric comorbidity, and inform referral

In the minimum dataset, these are only routinely administered prior to treatment, but clinicians may choose to screen at other times during treatment to inform their practice. These tools are not diagnostic so in the event that clients screen positive on these brief measures, more detailed assessment or referral to other services may be required. In this category, only no-cost self-report measures with 5 or fewer items are included.

Measurement to assess risk, screen for psychiatric comorbidity, and inform referral are the same set of brief screening instruments employed for gamblers: suicidal ideation, family/ whānau violence, hazardous alcohol use, other drug use, depression symptoms, and anxiety symptoms. Note that the depression and anxiety measures are recommended treatment outcomes so are described later in this section. For detailed information on the rationale for selecting these constructs and measures, please see Section 5.

| **Construct** | **Measure** | **Description** | **Administration and scoring** |
| --- | --- | --- | --- |
| Suicidal ideation | Suicide risk item currently employed in NZ gambling harm services and recommended by MoH | **Purpose**: to provide a single-item measuring thoughts of self-harm or suicide**Timeframe:** Past 12 months**Domains**: None | **Number of items**: 1**Response options**: 4-point scale from (0) no thoughts to (3) tried to harm myself**Scoring**: Scores can range from 0 to 3; higher scores indicate greater suicidal ideation; no cut-off |
| Family/whānau violence | Hurt-Insulted-Threatened-Screamed (HITS) – single item adaptations for victimisation and perpetration  | **Purpose**: to provide very brief screens for family/whānau violence victimisation and perpetration**Timeframe:** Past 12 months**Domains**: Victimisation, perpetration | **Number of items**: 2**Response options**: 4-point scale from (1) never to (5) frequently. **Scoring**: Each item should be scored separately. Scores on each item can range from 1 to 5; higher scores indicate greater family/whānau violence; no cut-off |
| Hazardous alcohol use | Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) | **Purpose**: to provide a very brief screen for hazardous alcohol use**Timeframe:** Current**Domains**: None | **Number of items**: 3**Response options**: 5-point scale from 0-4, with varying response labels**Scoring**: Add to obtain total score; higher scores indicate greater alcohol use issues; scores range from 0-12; cut-off scores: men (≥4), women (≥3) |
| Other drug use | Single-Question Screening Test for Drug Use in Primary Care | **Purpose**: to provide a single-item screening test for drug use and drug use disorders in primary care**Timeframe:** Past 12-months**Domains**: None | **Number of items**: 1**Response options**: Open text field**Scoring**: Higher scores indicate more frequent drug use; cut-off score: ≥1 |

There are two exceptions: (1) removal of the gaming screening instrument because there is no reason to expect comorbidity between affected other status and excessive gaming; and (2) the addition of a screening tool to detect own gambling symptoms given research evidence that a considerable proportion of affected others report harm resulting from their own gambling.

**Own harmful gambling.** There are now a plethora of brief screening instruments to detect “problem gambling”, most of which range from 2 to 5 items. Given we only require a brief measure, we have selected the One-Item Screen, which demonstrates acceptable classification accuracy in detecting “problem gambling”, relative to the Problem Gambling Severity Index.

| **Construct** | **Measure** | **Description** | **Administration and scoring** |
| --- | --- | --- | --- |
| Own harmful gambling | One-item screen | **Purpose**: To screen for problems arising from own gambling **Timeframe**: Past 12 months **Domains**: None | **Number of items**: 1 **Response options**: Binary scale (no, yes) **Scoring**: Score of 0 (no) or 1 (yes); cut-off score: 1 |

## Measurement of the impact of treatment

Psychological treatments for affected others tend to fall into the following categories: (1) treatments that aim to help the affected other manage the impacts of the behaviour of the person who gambles (affected other-focused treatments); and (2) treatments that aim to equip affected others to support the person who gambles into treatment or to reduce their gambling (gambler-focused treatments). We have therefore identified measures across these two foci. In the minimum dataset, these measures are routinely administered at multiple set timepoints at post-treatment and follow-up time periods. In this category, only no-cost self-report items with 15 or fewer items are included.

***Affected other-focused treatments***

Measurement of the impact of treatment on affected others are the same set of non-gambling outcomes employed for gamblers: depression symptoms, anxiety symptoms, functional impairment, and wellbeing/quality of life. For detailed information on the rationale for selecting these constructs and measures, please see Section 5 and see Appendix 4 for full screens.

| **Construct** | **Measure** | **Description** | **Administration and scoring** |
| --- | --- | --- | --- |
| Depression symptoms | Patient Health Questionnaire-2 (PHQ-2) | **Purpose**: to assess the presence and frequency of major depression symptoms**Timeframe**: Past 2-weeks**Domains**: None | **Number of items**: 2**Response options**: 4-point scale from (0) not at all to (3) nearly every day**Scoring**: Add to obtain total score; higher scores indicate greater depression symptoms; scores range from 0-6; cut-off scores: ≥3 indicates positive screen for major depression |
| Anxiety symptoms | Generalised Anxiety Disorder (GAD-2) | **Purpose**: to assess the frequency of generalised anxiety symptoms**Timeframe**: Past 2-weeks**Domains**: None | **Number of items**: 2**Response options**: 4-point scale from (0) not at all to (3) nearly every day**Scoring**: Add to obtain total score; higher scores indicate greater anxiety symptoms; scores range from 0-6; cut-off scores: ≥3 indicates positive screen for generalised anxiety disorder |
| Functional impairment | Work and Social Adjustment Scale (WSAS) | **Purpose**: to provide a brief and simple measure for impairment in functioning as a result of gambling**Timeframe**: Current**Domains**: None | **Number of items**: 5**Response options**: 9-point scale from (0) not at all to (8) very severely**Scoring**: Add to obtain total score; higher scores indicate more functional impairment; scores range from 0-40; cut-off scores: moderately severe (21-40), significant functional impairment (10-20), subclinical impairment (0-9) |
| Wellbeing/quality of life | EUROHIS-QOL-8*Supplemented by**Tangata Whaiora Questionnaire – Hua Oranga for cultural/spirituality reasons, where appropriate* | **Purpose**: to assess overall quality of life across diverse populations**Timeframe**: Past 2-weeks**Domains**: Physical health, psychological wellbeing, social relationships, environmental factors | **Number of items**: 8**Response options**: 5-point scale from (1) very poor to (5) very good**Scoring**: Add to obtain total score; higher scores indicate more positive quality of life; scores range from 8-40; no cut-off scores |

**Stress symptoms.** In addition, we recommend measuring stress symptoms given the prominent positioning of stress in the Stress-Strain-Coping-Support (SSCS model), which is the only contemporary conceptual model of affected other functioning. The SSCS views family members as principally ordinary people exposed to a set of stressful circumstances or conditions of adversity. We selected the to measure stress symptoms as it is the briefest and most economical version of the most widely measure of perceived stress. This scale has good reliability and validity.

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| **Construct** | **Measure** | **Description** | **Administration and scoring** |
| Stress symptoms | Perceived Stress Scale-4 (PSS-4) | **Purpose**: To measure the degree to which situations in one’s life over the past month are appraised as stressful (i.e., detect how unpredictable, uncontrollable, and overloaded people find their lives) **Timeframe**: Past-month **Domains**: None | **Number of items**: 4 **Response options**: 5-point scale from (0) never to (4) very often **Scoring**: Reverse score questions 2 and 3; add to obtain total score; higher score indicates more perceived stress; scores range from 0 to 16; no cut-off scores |

***Gambler-focused treatments***

**Gambling support self-efficacy.** Some gambling treatments evaluated for affected others, such as Community Reinforcement Approach and Training (CRAFT), blend both affected other and gambler-focused approaches. As well as aiming to improve the personal and relationship functioning of family members (affected other-focused outcomes), CRAFT also aims to engage gamblers in treatment and decrease their gambling (gambler-focused outcomes). We assert that gambler-focused outcomes, such as engaging gamblers in treatment and decreasing the gambling, are inappropriate aims for affected other treatments because the behaviour of another person is largely beyond their control. Instead, we believe it is more appropriate to measure the degree to which affected others feel confident in supporting their gambling family members or friends. This is the approach adopted by the 5-Step Method based on the SSCS, which is designed to support family members in their own right. Unfortunately, however, measures that measure affected other gambling support self-efficacy have not yet been developed. We therefore reviewed the caregiving literature and selected the Caregiver Self-Efficacy Scale (CSES-8) for inclusion in the minimum dataset. This brief measure includes the following content areas: obtaining respite, controlling negative thoughts, coping with new situations, stress management, self-care, finding resources, and preventing disruptive behaviours. It has demonstrated very good reliability and validity, as well as sensitivity to change.

| **Construct** | **Measure** | **Description** | **Administration and scoring** |
| --- | --- | --- | --- |
| Gambling support self-efficacy | Caregiver Self-Efficacy Scale (CSES-8) | **Purpose**: To evaluate self-efficacy in a range of caregiving situations  **Timeframe**: Current **Domains**: None | **Number of items**: 8 **Response options**: 10-point scale from (0) not at all confident to (4) totally confident **Scoring**: Add to obtain total score; higher score indicates higher self-efficacy; scores range from 8 to 80; tentative cut-off score: ≥7 |

## Measurement to inform treatment planning and assess processes of change

The SSCS model suggests that the degree to which the behaviours of people who gamble result in psychological and physical health problems in affected others is determined by both the ways family members cope with the stress, as well as the professional and informal social support they receive. For this reason, we have added very brief measures of coping and social support. These measures can be used to facilitate treatment planning or be examined as the mechanisms or processes of change, which are the underlying factors through which a treatment exerts it’s effects and leads to desired outcomes. In the minimum dataset, these measures are routinely administered at multiple set timepoints at post-treatment and follow-up time periods. In this category, only no-cost self-report measures with 15 or fewer items are included.

**Coping.** There are many coping measures available, but most are relatively long. For this reason, we selected four 2-item coping subscales from the Brief COPE, which is a commonly employed abbreviated version of the COPE Inventory. Although the authors of the Brief COPE indicate that they do not divide their subscales into adaptive or maladaptive coping, we identified those that, in the context of affected others, are adaptive (active coping, planning coping) and maladaptive (behavioural disengagement, self-blame). These subscales have acceptable reliability, validity, and sensitivity to change.

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| **Construct** | **Measure** | **Description** | **Administration and scoring** |
| Coping | Brief COPE – Active Coping, Planning Coping, Behavioural Disengagement, Self-Blame subscales | **Purpose**: To evaluate coping in response to stressful situations  **Timeframe**: Current **Domains**: 4 subscales: Active coping, Planning coping, Self-blame, Behavioural disengagement,  | **Number of items**: 8 (2 per subscale) **Response options**: 4-point scale from (1) I haven’t been doing this at all to (4) I’ve been doing this a lot **Scoring**: Add to obtain total score for each subscale; higher subscale scores indicates greater coping; scores for each subscale range from 2 to 8; no cut-off scores |

**Social support.** We selected the Brief Social Support Scale (BS6) to measure tangible support and emotional-informational support. It is a reliable and valid short scale that assesses emotional and practical dimensions of social support.

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| **Construct** | **Measure** | **Description** | **Administration and scoring** |
| Social support | Brief Social Support Scale (BS6) | **Purpose**: To measure the emotional and practical dimensions of social support  **Timeframe**: Current **Domains**: 2 subscales: Tangible support, emotional-informational support | **Number of items**: 6 (3 per subscale) **Response options**: 4-point scale from (1) never to (4) always **Scoring**: Add to obtain total score for each subscale; higher subscale scores indicate greater social support; scores for each subscale range from 3 to 12; no cut-off scores |

## Measurement of client satisfaction

At post-treatment and follow-up timepoints, it is important to assess client satisfaction with the service provided. Measuring client satisfaction with treatment helps assess the effectiveness and quality of the intervention from the client’s perspective, providing valuable feedback for improvement. It can also enhance engagement and retention, ensuring that the treatment aligns with the clients' needs and expectations. As for people who gamble, we selected the Client Satisfaction Questionnaire-4 (CSQ-4) for inclusion in the minimum dataset (refer to Section 5).

| **Construct** | **Measure** | **Description** | **Administration and scoring** |
| --- | --- | --- | --- |
| Client satisfaction | Client Satisfaction Questionnaire-4 (CSQ-4) | **Purpose**: to assess consumer satisfaction with health and human services**Timeframe**: Current**Domains**: None | **Number of items**: 4**Response options**: 4-point scale, from 1-4, with varying response options**Scoring**: Add to obtain total score; scores range from 4 to 16, higher scores indicate higher treatment satisfaction; no cut-off scores |

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# Appendices

## Appendix 1. Recommended intake measures: Items and scoring – Gambling

**INTAKE: DESCRIPTION OF PEOPLE WHO GAMBLE AND ARE ACCESSING THE SERVICE**

|  |  |
| --- | --- |
| POST CODE: | YOUR GENDER: |
| ETHNICITY: | YOUR AGE: |
| HOUSEHOLD INCOME (BEFORE TAX): |
| **Of the gambling types listed below, which one have you lost most of your money in the past 12 months?***[Question adapted from the GAMTOMS16 assessment scale to determine activity most likely associated with harm]* |
| SPORTS | POKIES | CASINO |
| RACING | BINGO/HOUSIE | INSTANT KIWI |
| KENO | PRIVATE BETTING | LOTTERIES |
|   |
| **Of the gambling modes listed below, which one have you lost most of your money in the past 12 months?** |
| ONLINE | IN VENUE | OTHER: *Please specify* |
| **These questions are about any harm you may have experienced from gambling. For each item, consider the level of negative impact gambling had on the following areas during the past 12 months.** *[This is the 7-item Domain-General Gambling Harm Scale.17 Scores are calculated adding up the total number. Higher scores mean more gambling harms]* |
| Financial security | 0=No impact | 1=Minor impact | 2=Some impact | 3=Moderate impact | 4=Major impact |
| Personal relationships with family, friends, spouse, partner and whānau | 0=No impact | 1=minor impact | 2=some impact | 3=moderate impact | 4=Major impact |
| Emotional or psychological wellbeing | 0=No impact | 1=minor impact | 2=some impact | 3=moderate impact | 4=Major impact |
| Physical or mental health | 0=No impact | 1=minor impact | 2=some impact | 3=moderate impact | 4=Major impact |
| Law-abidingness like taking money or items from friends or family without asking first | 0=No impact | 1=minor impact | 2=some impact | 3=moderate impact | 4=Major impact |
| Work or study performance | 0=No impact | 1=minor impact | 2=some impact | 3=moderate impact | 4=Major impact |
| Cultural or religious community like feeling less connected or contributing less | 0=No impact | 1=minor impact | 2=some impact | 3=moderate impact | 4=Major impact |

**INTAKE: MEASUREMENT TO ASSESS RISK, SCREEN FOR PSYCHIATRIC COMORBIDITY, AND INFORM REFERRAL**

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| **Within the last 12 months have you had thoughts of self-harm or suicide?** *Current item recommended in MOH handbook and used in services* |
| Within the last 12 months: Have you had thoughts of self-harm or suicide?  | 0=No thoughts in the past 12 months | 1=Just thoughts | 2=Not only thoughts but I have also had a plan | 3=I have tried to harm myself in the past 12 months |
| In the past twelve months…*[Adapted HITS18,19 scale to measure victim and perpetrator or interpersonal violence. Scores can range from 4-20 with any score indicating harm].* |
| ...has a family member physically hurt you, insulted or talked down to you, threatened you with harm, or screamed or cursed at you? | 1=Never | 2=Rarely | 3=Sometimes | 4=fairly often | 5=Frequently |
| … have you physically hurt a family member, insulted or talked down to a family member, threatened a family member with harm, or screamed or cursed at a family member? | 1=Never | 2=Rarely | 3=Sometimes | 4=fairly often | 5=Frequently |
| **The Alcohol Use Disorders Identification Test-Concise (AUDIT-C) is a brief alcohol screening instrument. Please give a response for each question.** *[AUDIT-C20 has 3 questions and is scored on a scale of 0-12. Each AUDIT-C question has 5 answer choices valued from 0 points to 4 points. In men, a score of 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders. In women, a score of 3 or more is considered positive. Generally, the higher the score, the more likely it is that a person's drinking is affecting his or her safety.]* |
| How often do you have a drink containing alcohol? | 0=never | 1=monthly or less | 2=two to four times a month | 3=two to three times a week | 4=four or more times a week |
| How many standard drinks containing alcohol do you have on a typical day? | 0 = None, I do not drink AND  | 0=1 or 2 | 1=3or 4 | 2= 5 or 6 | 3=7-9 | 4=10 or more |
| How often do you have six or more drinks on one occasion? | 0=Never | 1=Less than monthly | 2=Monthly | 3=weekly | 4=daily or almost daily |
| *[A Single-Question Screening Test for Drug Use in Primary Care21 is scored as a response of at least 1 time is considered positive for drug use)* |
| How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons? | OPEN TEXT FIELD |
| **The TIGTOC is a screen for gaming problems including video, internet, mobile and console games. What have your experiences been over the past 12 months?***[TIGTOC22 is a three item screen for gaming disorder is scored from 0-9 with a cut point of 4 or more indicating gaming problems)* |
| I have tried to cut down on playing Internet games, but I have not been successful. | 0=I have not gamed in the past 12 months | 0=Not at all | 1=Occasionally | 2=Frequently | 3=Always |
| I have lost interest in other hobbies or recreational activities I enjoyed beforebecause of Internet games. | 0=I have not gamed in the past 12 months | 0=Not at all | 1=Occasionally | 2=Frequently | 3=Always |
| Despite social and psychological problems, I continue playing Internet games excessively. | 0=I have not gamed in the past 12 months | 0=Not at all | 1=Occasionally | 2=Frequently | 3=Always |

## Appendix 2. Recommended outcome measures: Items and scoring – Gambling

**MEASUREMENT OF THE IMPACT OF TREATMENT (GAMBLING IMPACT)**

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| **Please answer each of the following in the past week Please read the questions carefully before you answer.***[G-SAS23 measures gambling urges, thoughts and gambling behaviour and is scored from 0-48 by adding up the total scores. Categories of gambling severity can be calculated – Mild = 8-20, Moderate = 21-30, Severe = 31-40, Extreme = over 40.]* |
| 1. If you had unwanted urges to gamble, on average, how strong were your urges?
 | 0 = None | 1 = Mild | 2 = Moderate | 3 = Strong | 4 = Extreme |
| 1. How many times did you experience urges to gamble?
 | 0=None | 1=Once | 2=Two to three times | 3=Several to many times | 4=Constant or near constant |
| 1. How many hours (add up hours) were you preoccupied with your urges to gamble?
 | 0=None | 1=1hours or less | 2=1 to 7 hours | 3=7 to 21 hours | 4=over 21 hours |
| 1. How much were you able to control your urges to gamble?
 | 0=Complete | 1=Much | 2=Moderate | 3=Minimal | 4=No control |
| 1. How often did thoughts about gambling and placing bets come up?
 | 0=None | 1=Once | 2=Two to four times | 3=Several to many times | 4=Constantly or nearly constantly |
| 1. How many hours (add up hours) did you spend thinking about gambling and thinking about placing bets?
 | 0=None | 1=1 hours or less | 2=1 to 7 hours | 3=7 to 21 hours | 4=over 21 hours |
| 1. How much were you able to control your thoughts of gambling
 | 0=Complete | 1=Much | 2=Moderate | 3=Minimal | 4=None |
| 1. Approximately how much time did you spend gambling or on gambling-related activities?
 | 0=None | 1=2 hours or less | 2=2 to 7 hours | 3=7 to 21 hours | 4=over 21 hours |
| 1. How much anticipatory tension and/or excitement did you feel shortly before engaging in gambling?
 | 0 = None | 1 = Mild | 2 = Moderate | 3 = Strong | 4 = Extreme |
| 1. How much excitement and pleasure did you feel when you won a bet? If you did not actually win at gambling, please estimate how much excitement and pleasure you would have experienced if you had won.
 | 0 = None | 1 = Mild | 2 = Moderate | 3 = Strong | 4 = Extreme |
| 1. How much emotional distress (mental pain or anguish, shame, guilt, embarrassment) has your gambling caused you?
 | 0 = None | 1 = Mild | 2 = Moderate | 3 = Strong | 4 = Extreme |
| 1. How much personal trouble (financial, legal, relationship issues) has your gambling caused you?
 | 0 = None | 1 = Mild | 2 = Moderate | 3 = Strong | 4 = Extreme |

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| **These next questions are about gambling in a venue like pokies, casino, lotteries or bingo.** *[Global expenditure and frequency items24 measure money and days spent gambling over the past month]* |
| In the past month, how many **days** did you gamble in total on pokies, casino, lotto, bingo or other in-venue gambling? | OPEN TEXT FIELD |
| In the past month, how much did you **spend** in total on pokies, casino, lotto, bingo or other in-venue gambling? | $ |
| **These next questions are about gambling online like racing or sports through an app or website**  |
| In the past month, how many **days** did you gamble in total on racing, sports or other online or app-based gambling?  | OPEN TEXT FIELD |
| In the past month, how much did you **spend** in total on racing, sports or other online or app-based gambling? | $ |

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| **The next questions are about your gambling goals over the past 4 weeks and then the next four weeks.** *[The Recovery Index for Gambling Disorder (RIGD)25 contains a sub-group of items that measure reduction of gambling to meet personal goals and self-efficacy relating to continued maintenance of reduced gambling. Clients are asked about past and future goals and the degree to which these are achieved or expected to be achieved]* |
| Please select the option that best represents your personal goals in relation to your gambling **during the past 4 weeks.** | Avoid all gambling entirely | Avoid the specific type/s of gambling that cause me the most problems | Continue gambling on any type, but at an affordable level |
| To what extent did you achieve this goal in the past 4 weeks | 1=Not at all | 2=Very little | 3=Somewhat | 4=Moderately | 5=Completely |
| We would also like to know if you wish to keep or change your goal for the next 4 weeks. |
| Please select the option that best represents your personal gambling goal **for next month.** | Avoid all gambling entirely | Avoid the specific type/s of gambling that cause me the most problems | Continue gambling on any type, but at an affordable level |
| In the next 4 weeks, how confident are you that you will achieve this goal? | 1=Not at all | 2=Not very | 3=Somewhat | 4=Moderately | 5=Very confident |

**MEASUREMENT OF THE IMPACT OF TREATMENT (NON-GAMBLING OUTCOMES)**

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| **Over the last 2 weeks, how often have you been bothered by any of the following problems?***[PHQ-226 scores range from 0-6 and scores of 3 or more indicate major depression]* |
| Little interest or pleasure in doing things | 0=Not at all | 1=several days | 2=more than half the days | 3=nearly everyday |
| Feeling down, depressed, or hopeless | 0=Not at all | 1=several days | 2=more than half the days | 3=nearly everyday |
| **Over the last 2 weeks, how often have you been bothered by any of the following problems?***[GAD-2 scores range from 0-6 and scores of 3 or more indicate anxiety]* |
| Feeling nervous, anxious or on edge  | 0=Not at all | 1=several days | 2=more than half the days | 3=nearly everyday |
| Not being able to stop or control worrying | 0=Not at all | 1=several days | 2=more than half the days | 3=nearly everyday |
| **This set of questions asks how you feel about your quality of life, health or other areas of your life. We ask that you think about your life in the past two weeks.** *[EUROHIS27 scores range from 8-40 measures quality of life by summing up the scores on 8 items with higher scores indicating better quality of life]* |
| How would you rate your quality of life | 1 = Very poor  | 2 = poor | 3 = Neither poor nor good | 4 = Good | 5 = Very good |
| How satisfied are you with your health | 1 = Not at all | 2 = A little | 3 = Moderately | 4 = Mostly | 5 = Completely |
| Do you have enough energy for everyday life | 1 = Not at all | 2 = A little | 3 = Moderately | 4 = Mostly | 5 = Completely |
| How satisfied are you with your ability to perform your daily activities | 1 = Not at all | 2 = A little | 3 = Moderately | 4 = Mostly | 5 = Completely |
| How satisfied are you with yourself | 1 = Not at all | 2 = A little | 3 = Moderately | 4 = Mostly | 5 = Completely |
| How satisfied are you with your personal relationships | 1 = Not at all | 2 = A little | 3 = Moderately | 4 = Mostly | 5 = Completely |
| Have you enough money to meet your needs | 1 = Not at all | 2 = A little | 3 = Moderately | 4 = Mostly | 5 = Completely |
| How satisfied are you with the conditions of your living place | 1 = Not at all | 2 = A little | 3 = Moderately | 4 = Mostly | 5 = Completely |

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| --- |
| **Rate each of the following questions on a scale of 0=not at all to 8 = very severe impairment. Because of my gambling….***[The total WSAS28 score is calculated by adding up all of the items. A WSAS score above 20 appears to suggest moderately severe or worse psychopathology. Scores between 10 and 20 are associated with significant functional impairment but less severe clinical symptomatology. Scores below 10 appear to be associated with subclinical populations].* |
|  | Not at all |  | Slightly |  | Definitely |  | Markedly |  | Very severely |
| …my ability to work is impaired. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| … my home management (e.g., cleaning, tidying, shopping, cooking, looking after home or children, paying bills) is impaired. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| … my social leisure activities (e.g., with other people, such as parties, bars, clubs, outings, visits, dating, home entertaining) are impaired. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| … my private leisure activities (e.g., done alone, such as reading, gardening, collecting, sewing, walking alone) are impaired. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| … my ability to form and maintain close relationships with others, including those I live with, is impaired. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |

MEASUREMENT TO INFORM TREATMENT PLANNING AND ASSESS PROCESSES OF CHANGE

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| **On a scale of 1 to 10….**[Readiness rulers29 assess importance, readiness and confidence on a 10-point scale with high importance and readiness indicating receptivity to change which is often paired with low confidence to resist and urge]. |
| How important is it for you that you limit/stop your gambling? | 1=Not important at all, 10 = Totally important |
| Where does limiting/stopping gambling fit on your list of priorities? | 1=Not a priority at all, 10 = Highest priority |
| How confident are you that you could deal with an unexpected urge to gamble? | 1=Not at all confident to 10 = Totally confident |
| **Rate each of the following questions on a scale of 1=do not agree at all to 7 = Agree completely.** [Jonsson-Abbott Scale – Gambling Fallacy subscale30,31 examines gambling beliefs that may contribute towards continued gambling. Higher scores indicate the strong beliefs about winning at gambling.  |
|  | Do not agree at all |  |  |  |  |  | Agree completely |
| My gambling is a way to make money | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| When I win, it is due to my skill | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| If I just gamble enough, my gambling will pay off | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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| NOTE FINAL ITEM IN THIS SECTION IS THE URGE SUB-SCALE FROM THE GAMBLING SYMPTOM ASSESSMENT SCALE – URGES. IF NOT ADMINISTERING THE FULL SCALE EARLIER THEN THIS SECTION SHOULD BE ADMINIISTERED HERE. |

MEASUREMENT OF CLIENT SATISFACTION

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| **Please help us improve our program by answering some questions about the services you have received. We are interested in your honest opinion, whether they are positive or negative.***[The Client Satisfaction Questionnaire -432,33 scores range from 4-16 with higher scores indicating greater service satisfaction].* |
| To what extent has our program met your needs? | 1=None of my needs have been met | 2=Only a few of my needs have been met | 3=Most of my needs have been met | 4=Almost all of my needs have been met |
| Have the services you received helped you to deal more effectively with gambling harm?  | 1= No, they seem to make things worse | 2=No, they really didn’t help | 3=Yes they helped somewhat | 4=Yes, they helped a great deal |
| In an overall, general sense, how satisfied are you with the service you have received? | 1= Quite dissatisfied | 2=Indifferent or mildly dissatisfied | 3=Mostly satisfied | 4=Very satisfied |
| If you were to seek help again, would you come back to our program*?* | 1= No, definitely not | 1=I don’t think so | 2=Yes, I think so | 4=Yes, definitely |

## Appendix 3. Recommended intake measures: Items and scoring – Affected others

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| --- | --- |
| **In the past 12 months how many people in total have you had a close relationship with****who have gambled? \* ‘Close relationship’ is often a family member, is one in which you know each other well, you care about each other, and you depend on each other.34** | OPEN TEXT OPTION |
| **Thinking about the other person whose gambling has negatively affected you the most, what best describes their relationship to you?34** | Current spouse/partner | Son | Other whānau |
| Former spouse/partner | Daughter | Other relative |
| Father or father in-law | Sister/brother | Friend |
| Mother or Mother in-law | Grandparent | Work colleague |
| Other person (state) |
| **For the following questions please think about the other person whose gambling negatively affected you the most. During the last 12 months, did any of these issues occur to you as a result of the person’s gambling?** *[The Gambling Harm Scale-10 for Affected Others34 is scored by counting the number of 'yes' responses. The total score ranges from 0 to 10, with higher scores indicating greater gambling harm].* |
| Late payments on bills like utilities or rates | 1=Yes | 0=No |
| Reduced performance at work or study (i.e. due to tiredness or distraction)  | 1=Yes | 0=No |
| Loss of sleep due to stress or worry about their gambling or gambling-related harm | 1=Yes | 0=No |
| Stress related health problems (e.g. high blood pressure, headaches)  | 1=Yes | 0=No |
| Increased experience of depression  | 1=Yes | 0=No |
| Feelings of hopelessness about their gambling  | 1=Yes | 0=No |
| Felt angry about not controlling their gambling  | 1=Yes | 0=No |
| Got less enjoyment from time spent with people I care about | 1=Yes | 0=No |
| Threat of separation or ending a relationship/s  | 1=Yes | 0=No |
| Took money or items from friends or family without asking first | 1=Yes | 0=No |

**MEASUREMENT TO ASSESS RISK, SCREEN FOR PSYCHIATRIC COMORBIDITY, AND REFERRAL**

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| **Within the last 12 months have you had thoughts of self-harm or suicide?** *Current item recommended in MOH handbook and used in services* |
| Within the last 12 months: Have you had thoughts of self-harm or suicide?  | 0=No thoughts in the past 12 months | 1=Just thoughts | 2=Not only thoughts but I have also had a plan | 3=I have tried to harm myself in the past 12 months |
| **In the past twelve months…***[Adapted HITS18,19 scale to measure victim and perpetrator or interpersonal violence]* |
| ...has a family member physically hurt you, insulted or talked down to you, threatened you with harm, or screamed or cursed at you? | 1=Never | 2=Rarely | 3=Sometimes | 4=fairly often | 5=Frequently |
| … have you physically hurt a family member, insulted or talked down to a family member, threatened a family member with harm, or screamed or cursed at a family member? | 1=Never | 2=Rarely | 3=Sometimes | 4=fairly often | 5=Frequently |
| **The Alcohol Use Disorders Identification Test-Concise (AUDIT-C) is a brief alcohol screening instrument. Please give a response for each question.** *[AUDIT-C20 has 3 questions and is scored on a scale of 0-12. Each question has 5 answer choices valued from 0 to 4 points. In men, a score of 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders. In women, a score of 3 or more is considered positive. Generally, the higher the score, the more likely it is that a person's drinking is affecting his or her safety.]* |
| How often do you have a drink containing alcohol? | 0=never | 1=monthly or less | 2=two to four times a month | 3=two to three times a week | 4=four or more times a week |
| How many standard drinks containing alcohol do you have on a typical day? | 0 = None, I do not drink  | 0=1 or 2 | 1=3or 4 | 2= 5 or 6 | 3=7-9 | 4=10 or more |
| How often do you have six or more drinks on one occasion? | 0=Never | 1=Less than monthly | 2=Monthly | 3=weekly | 4=daily or almost daily |
| *[A Single-Question Screening Test for Drug Use in Primary Care21 is scored as a response of at least 1 time is considered positive for drug use)* |
| How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons? | OPEN TEXT FIELD |
| In the past 12 months, have you had an issue with your gambling? | 1=Yes | 0=No |

## Appendix 4: Recommended outcome measures: Items and scoring - Affected others

MEASUREMENT OF THE IMPACT OF TREATMENT (AFFECTED OTHER FOCUS)

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| **Over the last 2 weeks, how often have you been bothered by any of the following problems?***[PHQ-226 scores range from 0-6 and scores of 3 or more indicate major depression]* |
| Little interest or pleasure in doing things | 0=Not at all | 1=several days | 2=more than half the days | 3=nearly everyday |
| Feeling down, depressed, or hopeless | 0=Not at all | 1=several days | 2=more than half the days | 3=nearly everyday |
| **Over the last 2 weeks, how often have you been bothered by any of the following problems?***[GAD-2 scores range from 0-6 and scores of 3 or more indicate anxiety]* |
| Feeling nervous, anxious or on edge  | 0=Not at all | 1=several days | 2=more than half the days | 3=nearly everyday |
| Not being able to stop or control worrying | 0=Not at all | 1=several days | 2=more than half the days | 3=nearly everyday |
| **The questions in this scale ask about your feelings and thoughts during THE LAST MONTH. For each question, please select the option that best represents HOW OFTEN you felt or thought a certain way.***[The Perceived Stress Scale 435 is a global measure of perceived stress. Total score ranges from 0-16 which is determined by adding together the scores of each of the four items. Questions 2 and 3 are reverse coded.]* |
| In the last month, how often have you felt that you were unable to control the important things in your life? | 0 = Never | 1=Almost never | 2=Some-times | 3=Fairly often | 4=Very often |
| In the last month, how often have you felt confident about your ability to handle your personal problems? | 4 = Never | 3=Almost never | 2=Some-times | 1=Fairly often | 0=Very often |
| In the last month, how often have you felt that things were going your way? | 4 = Never | 3=Almost never | 2=Some-times | 1=Fairly often | 0=Very often |
| In the last month, how often have you felt difficulties were piling up so high that you could not overcome them? | 0 = Never | 1=Almost never | 2=Some-times | 3=Fairly often | 4=Very often |
| **Rate each of the following questions on a scale of 0=not at all to 8 = very severe impairment. Because of gambling harm….***[The total WSAS28 score is calculated by adding up all of the items. A WSAS score above 20 appears to suggest moderately severe or worse psychopathology. Scores between 10 and 20 are associated with significant functional impairment but less severe clinical symptomatology. Scores below 10 appear to be associated with subclinical populations].* |
|  | Not at all |  | Slightly |  | Definitely |  | Markedly |  | Very severely |
| …my ability to work is impaired. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| … my home management (e.g., cleaning, tidying, shopping, cooking, looking after home or children, paying bills) is impaired. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| … my social leisure activities (e.g., with other people, such as parties, bars, clubs, outings, visits, dating, home entertaining) are impaired. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| … my private leisure activities (e.g., done alone, such as reading, gardening, collecting, sewing, walking alone) are impaired. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| … my ability to form and maintain close relationships with others, including those I live with, is impaired. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| **This set of questions asks how you feel about your quality of life, health or other areas of your life. We ask that you think about your life in the past two weeks.** *[EUROHIS27 scores range from 8-40 measures quality of life by summing up the scores on 8 items with higher scores indicating better quality of life]* |
| How would you rate your quality of life | 1 =Very poor | 2 =poor | 3 = Neither poor nor good | 4 = Good | 5 =Very good |
| How satisfied are you with your health | 1 =Not at all | 2 =A little | 3 = Moderately | 4 = Mostly | 5 =Completely |
| Do you have enough energy for everyday life | 1 =Not at all | 2 =A little | 3 = Moderately | 4 = Mostly | 5 =Completely |
| How satisfied are you with your ability to perform your daily activities | 1 =Not at all | 2 =A little | 3 = Moderately | 4 = Mostly | 5 =Completely |
| How satisfied are you with yourself | 1 =Not at all | 2 =A little | 3 = Moderately | 4 = Mostly | 5 =Completely |
| How satisfied are you with your personal relationships | 1 =Not at all | 2 =A little | 3 = Moderately | 4 = Mostly | 5 =Completely |
| Have you enough money to meet your needs | 1 =Not at all | 2 =A little | 3 = Moderately | 4 = Mostly | 5 =Completely |
| How satisfied are you with the conditions of your living place | 1 =Not at all | 2 =A little | 3 = Moderately | 4 = Mostly | 5 =Completely |

MEASUREMENT OF THE IMPACT OF TREATMENT (GAMBLER FOCUSED)

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| We are interested in how sure you are that you can keep up your own activities and also respond to situations that involve supporting your family member or friend(s) who gamble. For each of the following questions, please indicate the number that corresponds how sure you are that you can do the tasks regularly at the **present time.** *[Self-Administered Caregiving Self-Efficacy Scale- CSES-836 was developed to evaluate self-efficacy for caregivers across a range of situations. Scoring is from 8 to 80 with higher scores indicating more confidence in managing various situations; tentative cut-off score is 7 or higher.]* |
| How sure or confident are you that you have enough time away from caring for your family member or friend(s) to run errands. |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Not at all | | | | | | | | | | Totally confident 1 2 3 4 5 6 7 8 9 10 confident |
| How sure or confident are you that you can stop yourself from thinking about unpleasant aspects of taking care of your family member or friend(s)?  |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Not at all | | | | | | | | | | Totally confident 1 2 3 4 5 6 7 8 9 10 confident |
| How sure or confident are you that you can stop yourself from worrying about future problems that might come up with your family member or friend(s)?  |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Not at all | | | | | | | | | | Totally confident 1 2 3 4 5 6 7 8 9 10 confident |
| How sure or confident are you that you can cope with unexpected or new situations that may come up with your family member or friend(s)? |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Not at all | | | | | | | | | | Totally confident 1 2 3 4 5 6 7 8 9 10 confident |
| How sure or confident are you that you can do the things necessary to keep your stress under control?  |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Not at all | | | | | | | | | | Totally confident 1 2 3 4 5 6 7 8 9 10 confident |
| How sure or confident are you that you can do the things necessary to take care of your own health?  |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Not at all | | | | | | | | | | Totally confident 1 2 3 4 5 6 7 8 9 10 confident |
| How sure or confident are you that you can find resources in the community (e.g., financial, legal, support groups, etc.) that can help you take care of yourself and your family member or friend(s)?  |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Not at all | | | | | | | | | | Totally confident 1 2 3 4 5 6 7 8 9 10 confident |
| How sure or confident are you that you can sometimes prevent your family member or friend(s) from becoming angry or disruptive? |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Not at all | | | | | | | | | | Totally confident 1 2 3 4 5 6 7 8 9 10 confident |

MEASUREMENT TO INFORM TREATMENT PLANNING AND ASSESS PROCESSES OF CHANGE

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| **The following questions ask how you have sought to cope with gambling harm. Read the statements and indicate how much you have been using each coping style.***[Brief-COPE measures coping strategies people use in response to stress or challenging situations. Higher scores on Active coping (items 1,2) and Emotional support (items 3,4) indicate higher levels of adaptive coping. Higher scores on self-blaming (items 5,6) and behavioural disengagement (items 7,8) indicate more maladaptive coping.]* |
| I have been concentrating my efforts on doing something about the situation I’m in. [Active coping] | 1 = I haven’t been doing this at all | 2 = I’ve been doing this a little bit | 3= I’ve been doing this a medium amount | 4= I’ve been doing this a lot |
| I have been taking action to try to make the situation better. [Active coping] | 1 = I haven’t been doing this at all | 2 = I’ve been doing this a little bit | 3= I’ve been doing this a medium amount | 4= I’ve been doing this a lot |
| I have been getting emotional support from others. [Emotional support] | 1 = I haven’t been doing this at all | 2 = I’ve been doing this a little bit | 3= I’ve been doing this a medium amount | 4= I’ve been doing this a lot |
| I have been getting comfort and understanding from someone [Emotional support] | 1 = I haven’t been doing this at all | 2 = I’ve been doing this a little bit | 3= I’ve been doing this a medium amount | 4= I’ve been doing this a lot |
| I have been criticizing myself. [Self-blaming] | 1 = I haven’t been doing this at all | 2 = I’ve been doing this a little bit | 3= I’ve been doing this a medium amount | 4= I’ve been doing this a lot |
| I have been blaming myself for things that happened. [Self-blaming] | 1 = I haven’t been doing this at all | 2 = I’ve been doing this a little bit | 3= I’ve been doing this a medium amount | 4= I’ve been doing this a lot |
| I have been giving up trying to deal with it [Behavioural disengagement] | 1 = I haven’t been doing this at all | 2 = I’ve been doing this a little bit | 3= I’ve been doing this a medium amount | 4= I’ve been doing this a lot |
| I’ve been giving up the attempt to cope [Behavioural disengagement] | 1 = I haven’t been doing this at all | 2 = I’ve been doing this a little bit | 3= I’ve been doing this a medium amount | 4= I’ve been doing this a lot |
| **If you needed it, how often is someone available…***[The Brief Social Support Scale (BS6)37 is a six items scale measuring tangible support (items 1-3) and emotional-informational support (items 4-6). Higher subscale scores mean higher levels of social support].* |
| To take you to the doctor if you need it [Tangible support] | 1=Never | 2=Occasionally | 3=Mostly | 4=Always |
| To prepare your meals if you are unable to do it yourself [Tangible support] | 1=Never | 2=Occasionally | 3=Mostly | 4=Always |
| To help with daily chores if you were sick [Tangible support] | 1=Never | 2=Occasionally | 3=Mostly | 4=Always |
| To give you good advice about a crisis [Emotional-Informational support] | 1=Never | 2=Occasionally | 3=Mostly | 4=Always |
| To confide in or talk to about yourself or your problems [Emotional-Informational support] | 1=Never | 2=Occasionally | 3=Mostly | 4=Always |
| Who understands your problems [Emotional-Informational support] | 1=Never | 2=Occasionally | 3=Mostly | 4=Always |

MEASUREMENT OF CLIENT SATISFACTION

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| --- |
| **Please help us improve our program by answering some questions about the services you have received. We are interested in your honest opinion, whether they are positive or negative.***[The Client Satisfaction Questionnaire -4 32,33 scores range from 4-16 with higher scores indicating greater service satisfaction].* |
| To what extent has our service met your needs? | 1=None of my needs have been met | 2=Only a few of my needs have been met | 3=Most of my needs have been met | 4=Almost all of my needs have been met |
| Have the services you received helped you to deal more effectively with gambling harm?  | 1= No, they seem to make things worse | 2=No, they really didn’t help | 3=Yes they helped somewhat | 4=Yes, they helped a great deal |
| In an overall, general sense, how satisfied are you with the service you have received? | 1= Quite dissatisfied | 2=Indifferent or mildly dissatisfied | 3=Mostly satisfied | 4=Very satisfied |
| If you were to seek help again, would you come back to our service*?* | 1= No, definitely not | 1=I don’t think so | 2=Yes, I think so | 4=Yes, definitely |

## Appendix 5: Full report on clinician perspectives

### Background

In June to December 2022, a two-round Delphi study of Australian and New Zealand clinicians was conducted by Deakin University, led by Prof Nicki Dowling, to identify clinician perspectives on the most effective gambling treatments and techniques. Both surveys were administered online and participants were provided with a $100 e-gift voucher as reimbursement for their time and effort. This study was approved by Deakin University’s Human Research Ethics Committee (HeAG-H 11\_2021). This project provided important information, not only regarding clinician views on the effectiveness of gambling treatment and techniques, but also the training, use, confidence, and competency levels of gambling clinicians. In this report, we only present the descriptive information from the 14 New Zealand clinicians participating in the research. Of these participating clinicians, 10 completed both Rounds 1 and 2, 3 completed only Round 1, and one partially completed both Rounds 1 and 2. There are therefore slightly different sample sizes across this report.

### Sample description

New Zealand clinicians were recruited from PGF Services, the Salvation Army, and Asian Family Services. They were mostly female (n=11) and were aged between 29 and 68 years of age (M=51, SD=13). The service providers were a clinically experienced sample, with the majority reporting over five years working clinically (71%) and working clinically with people with gambling problems (50%). Over half had completed a postgraduate degree (57%) and most were employed full-time (71%). Most described their discipline qualification as social workers (36%), counsellors (29%), and alcohol or other drug workers (21%). Most described their main role in the sector as clinicians (50%) and case workers (36%). Most indicated they worked in organisations providing face-to-face treatment (93%); and that they had worked for face-to-face (100%), telephone (50%), and online/telehealth (21%) services in the past.

**Definitions of counselling approaches**

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| Therapy | Definition |
| Acceptance and commitment therapy  | Counsellor works with the client on their values and uses this to move toward meeting goals based on desired behaviour.  |
| Cognitive behavioural therapy  | Clinicians help clients to identify and replace learned unhelpful thoughts, emotions, and behaviours.  |
| Dialectical behaviour therapy | Four modes of therapy are delivered, designed to work on regulating emotions and learning new coping skills.  |
| Emotion-focused therapy | The counsellor and client work together to let go of unhelpful emotions such as anger and hurt, replacing them with healthier emotions such as acceptance and understanding. |
| Eye movement desensitisation | Cognitive processes are activated through concentrated eye movements to uncover traumatic experiences in the client’s history, which are examined and worked through between the counsellor and client.  |
| Family intervention | Dysfunctional relationships and interactions between family members are the focus of the counselling sessions.  |
| Hypnotherapy | The clinician guides the client into a semi-conscious state where changes in perceptions, thoughts and behaviour may take place.  |
| Interpersonal psychotherapy | Focusing on a client’s current problems, addressing causes of dysfunctional relationships in the clients’ life, and developing interpersonal skills such as communication.  |
| Mindfulness-based cognitive therapy / Mindfulness-based stress reduction  | Mindfulness meditations are taught to the client as a coping mechanism to assist with improving unhelpful thinking patterns.  |
| Motivational interviewing | Using change-motivating language to strengthen commitment and move toward achieving a goal.  |
| Narrative therapy | Therapist assists the client to describe their life story, working through their characterisations and providing guidance including reframing and emphasising strengths. Used often with members of First Nations communities.  |
| Psychodynamic psychotherapy | A talk therapy exploring a client’s history, their unconscious processes and underlying interpersonal conflicts.  |
| Psychoeducation | The clinician helps the clients to understand their disorder by presenting detailed information and guidance to the client about their diagnosis. |
| Solution-focused therapy | A brief resource-oriented and goal-focused therapeutic approach that helps individuals change by constructing solutions to problems they are facing. |
| Supportive psychotherapy | Problems are spoken about in a safe and non-judgemental environment, with the therapist providing validation and support during challenging experiences.  |

**Technique Definitions**

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| BCTs | Definition as provided to participants |
| Behaviour substitution | Behaviour substitution involves prompting the substitution of gambling behaviour with one or more non-problematic behaviours (e.g., pleasant activities, hobbies, social activities, and physical exercise). |
| Cognitive restructuring | Cognitive restructuring involves identifying maladaptive or inaccurate thoughts and beliefs related to gambling (e.g., misunderstanding of randomness), challenging the validity of those thoughts and beliefs, and identifying a more balanced alternative thought or belief. |
| Exposure | Exposure involves repeated systematic, gradual and controlled confrontation with gambling situations (e.g., gambling venues) and cues (e.g., watching a video of someone gambling). |
| Imaginal desensitisation | Imaginal desensitisation involves progressive application of relaxation approaches when intentionally exposed to a gambling related stimuli, image, or visualisation. |
| Problem solving | Problem solving involves prompting an individual to identify their gambling-related problems, generating various solutions to these problems, and evaluating and choosing a solution to implement (e.g., if gambling occurs due to high anxiety levels, problem solving may be used to help the individual identify other alternative ways of managing). |
| Self-monitoring | Self-monitoring involves establishing a method for the individual to record their own thoughts, feelings or behaviours over a specific time period (e.g., on a record sheet or in a diary). |
| Relapse prevention | Relapse prevention involves providing information about relapse (e.g., on the difference between a lapse and relapse), and supporting the development of a relapse prevention plan (e.g. identifying triggers, high-risk situations, and coping strategies). |
| Stimulus control | Stimulus control involves encouraging action to modify the environment to reduce access to gambling (e.g., restricting access to money or venues), or avoid situations that may trigger gambling cravings (e.g. avoiding specific people or places). |
| Decisional balance | Decisional balancing involves weighing up the pros and cons of behaviour change (e.g., weighing up the benefits of gambling with the benefits of not gambling, or the costs of gambling with the costs of not gambling). It also includes imagining positive outcomes of change, or identifying how gambling fits with life goals and values. |
| Feedback on assessment | Feedback on assessment involves providing the individual with a summary of the data that is collected about them on assessment measures. For example, providing them with information about how they scored on a problem gambling measure (e.g., gambling severity score) and the cut-off scores for this measure. |
| Goal setting | Goal setting involves setting goals or agreeing on goals within treatment. For example, setting a goal to limit, reduce or quit one or more gambling behaviours, or deciding on the amount of money that can be spent on gambling. Goal setting does not include goals set prior to the start of treatment (e.g., quit and abstain). |
| Information gathering | Information gathering involves asking strategic questions about the nature of the problem (sometimes referred to as Socratic Questioning). This may take place in an assessment session. |
| Information provision | Information provision includes providing information about problem gambling. This might include information about negative consequences and potential harms and risk factors of problem gambling, or information about the psychology of addiction and how gambling works (e.g. odds, randomness, and chance). |
| Motivational enhancement | Motivational enhancement involves exploring the individual’s awareness of their problem, exploring their ambivalence, capability and commitment to change, and increasing change talk. |
| Plan social support | Planning social support involves prompting an individual to make use of their support network. For example, it may include encouraging the individual to seek practical or emotional support from another person (such as family or friends or from online groups or forums), encouraging them to disclose gambling problem or goals for change with others, or encouraging them to socialise with others who are non-gamblers. |
| Social comparison | Social comparison involves a planned comparison of an individual’s gambling behaviours (e.g., frequency, expenditure, and time spent gambling) with those of another social group (e.g. a population of a specific age range, gender, or geographic location). |
| Financial management | Financial management involves providing the individual with information, instruction, guidance or support with reorganising finances, budgeting, or banking systems. |
| Social skills training | Social skills training involves working on interpersonal communication skills such as verbal communication and assertiveness, or other context specific interpersonal skills, such as refusal skills in situations where gambling is encouraged. |
| Mindfulness | Mindfulness involves encouraging an individual to pay attention or concentrate with purpose in each moment, without judgement, and to draw awareness to thoughts and feelings without trying to change them. |

### Results

*Clinician perspectives on intervention effectiveness*

Clinicians (n=14) rated the extent to which they disagreed or agreed with a set of statements considering both their clinical experience and the current evidence base. In the survey, participants rated the clinical questions posed in the NHMRC endorsed guideline for the screening, assessment, and treatment of problem gambling.38 Effectiveness was measured by reductions in gambling behaviour, gambling severity or psychological distress. Each statement was rated on a scale from (1) strongly disagree to (9) strongly agree.

*Intervention types*

Clinicians rated the extent to which they agreed with a set of statements: “For people with gambling problems, \_\_\_\_\_ are more effective than no intervention”. In the survey, participants could hover questions to view counselling definitions, which were sourced from the Australian Psychological Society’s *Evidence-based Psychological Interventions in the Treatment of Mental Disorders*.39 All definitions CBT and MI were not included as an intervention given there are evidence-based clinical guidelines endorsing the use of these interventions in the NHMRC endorsed guideline.38

As seen in Table 1, all but one clinician agreed (score of 7) or strongly agreed (score of 9) that psychoeducation and solution-focussed therapies were more effective than no intervention. A large majority of clinicians also endorsed the effectiveness of acceptance and commitment therapy, emotion-focused therapy, and family interventions. Hypnotherapy was the least endorsed therapy, followed by eye movement desensitisation and reprocessing, psychodynamic therapy, and interpersonal psychotherapy.

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| Table 1. Clinician perspectives on effectiveness of intervention types |
| Intervention type | Agree to strongly agree (n,%) |
| Psychoeducation | 13 (93%) |
| Solution-focused therapies | 13 (93%) |
| Acceptance and commitment therapy | 12 (86%) |
| Emotion-focused therapy | 12 (86%) |
| Family interventions | 12 (86%) |
| Narrative therapy | 11 (79%) |
| Mindfulness-based cognitive therapy/stress reduction | 11 (79%) |
| Dialectical behaviour therapy | 10 (71%) |
| Interpersonal psychotherapy | 9 (64%) |
| Psychodynamic psychotherapy | 9 (64%) |
| Eye movement desensitisation and reprocessing | 7 (50%) |
| Hypnotherapy | 3 (21%) |

*Treatment modalities and goals*

Clinicians rated the extent to which they disagreed or agreed with a set of statements relating to treatment modalities and goals: “For people with gambling problems, \_\_\_\_\_ are more effective than \_\_\_\_\_”. As indicated in Table 2, in relation to the intensity of treatment, over two-thirds agreed or strongly agreed that practitioner-delivered psychological interventions are more effective than non-practitioner-delivered psychological interventions, with prolonged practitioner-delivered interventions being more effective than brief practitioner-delivered interventions, but that non-practitioner delivered psychological interventions are more effective than no intervention. Most clinicians agreed that group interventions are more effective than no intervention. About half agreed that abstinence goals are more effective than non-abstinence goals and that interventions with non-abstinence goals are better than no intervention.

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| Table 2. Clinician perspectives on effectiveness of treatment modalities and goals |
| Treatment modalities and goals | Agree to strongly agree (n,%) |
| Treatment intensity |  |
| Practitioner-delivered cf. non-practitioner-delivered interventions | 9 (64%) |
| Non-practitioner-delivered interventions cf. no intervention | 9 (64%) |
| Prolonged- cf. brief practitioner-delivered interventions  | 9 (64%) |
| Non-practitioner-delivered interventions cf. self-help interventions | 3 (21%) |
| Inpatient cf. community interventions | 2 (14%) |
| Individual vs group delivery |  |
| Group interventions cf. no intervention | 11 (79%) |
| Individual interventions cf. group interventions | 3 (21%) |
| Treatment goals |  |
| Interventions with abstinence goal cf. non-abstinence goal | 8 (57%) |
| Interventions with non-abstinence goal cf. no intervention | 7 (50%) |

*Priority populations*

Clinician rated the extent to which they disagreed or agreed with a set of statements generally phrased as: “For \_\_\_\_, psychological interventions are more effective are more effective than no intervention or any other intervention (Table 3). For people with psychiatric comorbidities, both genders (men, women), age (young people, seniors), and gambling activities (electronic gaming machines [EGMs] and gambling other than EGMs), most clinicians agreed or strongly agreed that psychological interventions are more effective than no intervention, but few agreed that they were better than any other intervention. In terms of sequencing for psychiatric comorbidities, few clinicians agreed that sequenced interventions are more effective than simultaneous interventions (n=2, 21%) or that interventions with gambling treated first are more effective than interventions with comorbidities treated first (n=2, 14%).

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| Table 3. Clinician perspectives on treatment effectiveness for priority populations |
| Priority populations | Agree to strongly agree (n,%) |
|  | Cf. no intervention | Cf. any other intervention |
| People with psychiatric comorbidities | 11 (79%) | 7 (50%) |
| Women | 13 (93%) | 5 (36%) |
| Men | 11 (79%) | 6 (43%) |
| Young people | 12 (86%) | 4 (29%) |
| Seniors | 12 (86%) | 3 (21%) |
| EGMs | 12 (86%) | 5 (36%) |
| Gambling other than EGMs | 12 (8%) | 3 (21%) |

*Therapy training*

Clinicians (n=11) were asked the highest level of training or education they had received in both CBT and MI. All participants had completed training in both CBT and MI, with the profiles looking almost identical for each type of therapy. For CBT, five participants had completed a basic accredited course, three had completed a very short course (e.g., seminar of a few hours to 2 days), and three had completed an advanced accredited course. For MI, five participants had completed a basic accredited course, four had completed a very short course, and two had completed an advanced accredited course.

*Therapy use*

Clinicians (n=11) were asked what proportion of their time was spent employing each of the types of therapy in their work with gambling clients. Responses needed to add to 100% across the techniques. As seen in Table 4, all clinicians used CBT and MI and these treatments had the highest proportions of use. Supportive psychotherapy, psychoeducation, mindfulness-based cognitive therapy/stress reduction, family interventions, narrative therapy, and solution-focused therapy were used by over half of the clinicians and had the next highest proportions of use. Finally, clinicians rarely used hypnotherapy, eye movement desensitisation and reprocessing, psychodynamic psychotherapy, and dialectical behaviour therapy.

*Therapy confidence*

Clinicians (n=11) were asked to rate their confidence level in practising each of the therapy techniques using an item with 5-point scale from (1) not at all confident to (5) very confident. Table 4 indicates that most participants were fairly or very confident in using CBT and MI, followed by psychoeducation and mindfulness-based cognitive therapy/stress reduction. Conversely, few clinicians reported confidence using hypnotherapy, eye movement desensitisation and reprocessing, emotion-focussed therapy, and dialectical behaviour therapy.

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| Table 4. Therapy use and confidence |  |  |
| Therapy type | Therapy use | Therapy confidence |
| Clinicians using therapy (n,%) | Average proportion of time used  | Fairly or very confident(n,%) |
| Cognitive behavioural therapy | 11 (100%) | 21% | 10 (91%) |
| Motivational interviewing | 11 (100%) | 17% | 11 (100%) |
| Supportive psychotherapy | 9 (82%) | 13% | 7 (64%) |
| Psychoeducation | 8 (73%) | 10% | 8 (73%) |
| Mindfulness-based cognitive therapy / Mindfulness-based stress reduction | 7 (64%) | 5% | 8 (73%) |
| Family interventions | 7 (64%) | 5% | 6 (55%) |
| Narrative therapy | 7 (64%) | 6% | 4 (36%) |
| Solution-focused therapy | 6 (55%) | 8% | 7 (64%) |
| Acceptance and commitment therapy | 5 (46%) | 5% | 4 (36%) |
| Emotion-focused therapy | 5 (46%) | 3% | 2 (18%) |
| Interpersonal psychotherapy | 4 (36%) | 3% | 4 (36%) |
| Dialectical behaviour therapy | 2 (18%) | <1% | 2 (18%) |
| Psychodynamic psychotherapy | 1 (9%) | <1% | 3 (27%) |
| Eye movement desensitisation and reprocessing | 1 (9%) | <1% | 1 (9%) |
| Hypnotherapy | 1 (9%) | <1% | 0 (0%) |

*Therapy competence*

Clinicians (n=11) were asked to self-rate their competency levels as a counsellor treating clients with gambling problems. The scores were measured on a Likert scale from 0 to 10, with 0 indicating no skill at all, 5 indicating moderate skill level and 10 indicating master skill level. The competency questions were derived by combining the non-overlapping constructs from two direct competency measures: the Yale Adherence and Competence Scale (YACS) 40 and the Cognitive Therapy Self-Rating Scale (CTSS).41 The four resulting self-report subscales included CBT (18 items), MI (9 items), General Support (7 items) and Assessment (5 items), as well as four supplementary questions related to the therapeutic relationship, treatment goals, and termination. For each subscale, the total score was divided by the number of items so that competency scores were standardised across subscales.

Table 5 displays the subscale and item scores for each of the competency items. On average, clinicians rated themselves between moderate (score of 5) and master skill (score of 10) competency levels for all subscales, with means ranging from 8.5 to 8.7. The level of competency was highest for MI (M = 8.7) and General Support (M = 8.6), with CBT (M=8.5) and Assessment (M=8.5). In the CBT subscale, the items with the highest endorsement were exploring cravings, triggers or urges, planning for high-risk situations, using guided discovery, and exploring past high-risk situations and those with the lowest endorsement were initiating role-plays, eliciting client feedback, using homework assignments, and formulating case conceptualisation. In the MI subscale, the items with the highest endorsement were fostering a collaborative atmosphere and making reflective statements and those with the lowest endorsement were prompting commitment to change plans and motivational interviewing style. In the General Support subscale, the items with the highest endorsement were displaying interpersonal effectiveness and praising efforts to change, while those with the lowest endorsement were discussing support by affected others and demonstrating empathy. In the Assessment subscale, the items with the highest endorsement were assessing gambling disorder and general functioning, while those with the lowest endorsement were assessing alcohol and other drug use. Of the four supplementary items, the items with the highest endorsements were addressing client commitment to the treatment goal, followed by discussing client treatment goals, preparing for termination and exploring the therapeutic relationship.

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| Table 5. Therapy competence scores |
| Skill | Item | Average score |
| Cognitive Behaviour Therapy (CBT) | 8.5 |
| Exploring cravings, triggers, or urges | Explore specific cravings, triggers, or urges for gambling for the purpose of labelling them as a trigger or urging clients to avoid them | 9.3 |
| Planning for high-risk situations | Encourage clients to anticipate and plan coping strategies for high risk situations | 9.0 |
| Using guided discovery | Use questioning format, rather than debate, persuasion or lecturing to assist clients in reaching conclusions | 9.0 |
| Exploring past high-risk situations | Discuss high risk situations clients encountered in the past, and explore specific actions that were taken to avoid or cope with the situation | 8.9 |
| Collaborating | Encourage clients throughout the session to be active in therapy and work as a team with clients | 8.6 |
| Pacing sessions | Pace sessions well so the session time allows for a clear beginning, middle, and closing of the session | 8.6 |
| Setting an agenda | Set and implement a specific agenda for the session such as a session topic or list of issues to be discussed | 8.9 |
| Differentiating a slip and a relapse | Convey to clients that a slip involving a gambling event does not have to become a full relapse  | 8.5 |
| Reviewing homework | Review client reactions to the previous session’s assigned tasks (e.g., explore difficulties encountered, provide background information, reinforce importance skills practice) | 8.5 |
| Monitoring gambling-related cognitions | Ask clients to monitor or report specific thoughts associated with gambling | 8.4 |
| Focusing on key cognitions | Focus on key thoughts and help clients clearly delineate the content and nature of dysfunctional or unbalanced thinking | 8.4 |
| Using coping skills training | Attempt to teach, model, rehearse, review, or discuss specific coping skills, label them as such, and link them to past or future gambling | 8.4 |
| Applying cognitive techniques | Have a broad repertoire of cognitive techniques and move easily and quickly between various techniques as appropriate | 8.4 |
| Applying behavioural techniques | Have a broad repertoire of behavioural techniques and move easily and quickly between various techniques as appropriate | 8.4 |
| Formulating case conceptualisation | Use assessment to formulate a case conceptualisation that eventuates in a series of organised treatment interventions | 8.3 |
| Using homework assignments | Develop one or more specific homework tasks collaboratively with clients that is drawn directly from session material to test ideas, try new experiences, and experiment with new ways of responding | 8.2 |
| Eliciting client feedback | Continually check with clients to determine their understanding of the strategies and techniques being used in the session | 8.0 |
| Initiating role-plays | Initiate role-plays during the session and set and act out a scene and process what occurred | 7.2 |
| Motivational interviewing (MI) | 8.7 |
| Fostering a collaborative atmosphere | Treat clients as partners or collaborators, including allowing their perspectives to help guide treatment and to emphasize that clients are in control of their recovery | 9.1 |
| Making reflective statements | Repeat, rephrase paraphrase, or make reflective summary statements of what clients are saying | 9.0 |
| Using open-ended questions | Use open-ended questions to elicit client perceptions of their problems, motivation, change efforts, and plans | 8.9 |
| Exploring pros, cons, and ambivalence | Use techniques that recognise ambivalence as part of the normal change process such as a decisional balance, cost-benefits analysis or pros and cons or gambling and change | 8.9 |
| Affirming strengths and self-efficacy | Reinforce, compliment, recognise or affirm client strengths, ability or efforts to change gambling behaviours | 8.8 |
| Supporting change talk | Prompt client desire, ability, reasons, or need for change through questions or comments designed to support change talk and reduce sustain talk | 8.8 |
| Heightening discrepancies | Facilitate or increase awareness of a discrepancy between where life is currently versus where life could be in the future or how gambling can prevent the client from reaching life goals or values | 8.6 |
| Motivational interviewing style | Provide low-key feedback, roll with resistance, avoid arguing for change, and use a supportive, warm, non-judgemental approach | 8.4 |
| Prompting commitment to change plans | Prompt commitment to a change plan that includes collaborative discussion of positive and negative aspects of change, what might get in the way, and how to address impediments to change | 8.1 |
| General support |  | 8.6 |
| Displaying interpersonal effectiveness | Display high levels of warmth, concern, confidence, and genuineness | 9.2 |
| Praising efforts to change | Compliment or praise client efforts to change | 8.9 |
| Exploring feelings | Help clients to explore feelings related to current symptoms or gambling behaviours | 8.8 |
| Demonstrating professionalism | Have confidence in your ability and communicate that confidence to clients | 8.6 |
| Communicating optimistic reassurance | Communicate confidence that client efforts will be successful in behaviour change | 8.5 |
| Discussing support by affected others | Discuss the availability and nature of support from family members or friends to support treatment or behaviour change efforts | 8.3 |
| Demonstrating empathy | Demonstrate an understanding of the internal reality of clients and restate or reflect this in a way that is acceptable to clients | 8.1 |
| Assessment | 8.5 |
| Assessing gambling disorder | Assess gambling behaviours, including the patterns of gambling  | 8.8 |
| Assessing general functioning | Assess the level of functioning in major life areas such as work, family and relationships, social life or everyday stress | 8.8 |
| Assessing psychopathology | Assess psychopathology like symptoms of depressive, anxiety, or psychotic disorders | 8.5 |
| Assessing alcohol use | Assess drinking, including the patterns of alcohol use | 8.4 |
| Assessing other drug use | Assess the use of other substances like drugs, cigarettes or caffeine and their relationship to gambling | 8.2 |
| Supplementary items |
| Addressing client commitment to the treatment goal | Discuss or address client commitment to abstinence or reduction of gambling behaviours | 9.0 |
| Discussing client treatment goals | Discuss, review, or reformulate client goals for treatment | 8.5 |
| Preparing for termination | Prepare clients for the end of the therapeutic relationship and treatment by exploring their thoughts or feelings towards termination | 8.4 |
| Exploring the therapeutic relationship | Explore client thoughts or feelings regarding the therapeutic relationship or your interactions | 8.2 |

Adapted from the Yale Adherence and Competence Scale (YACS) (Carroll et al., 2000) and the Cognitive Therapy Self-Rating Scale (CTSS) (Bennett-Levy & Beedie, 2007).

*Clinician perspectives on treatment techniques*

Clinicians were asked to rate the effectiveness, use, and confidence with treatment techniques taken from the gambling behaviour change taxonomy, known as the Gambling Intervention System of CharacTerization (GIST-1).4

*Treatment technique effectiveness*

Clinicians (n=13) rated how effective they thought various treatment techniques are for bringing about clinically helpful change in someone with gambling problems based on their knowledge of the research literature, relevant theory, and their clinical experience (Table 6). Clinically helpful change was defined as reductions in gambling severity, gambling expenditure and gambling frequency. Each statement was rated on a scale from (1) not at all effective; (5) somewhat effective; (9) very effective. In the survey, participants could hover each technique to view the definitions. Table 6 reveals that all clinicians reported that cognitive restructuring and goal setting are effective techniques, while nearly all clinicians believed that relapse prevention, information gathering, information provision, financial management, and planning social support are effective techniques. In contrast, few clinicians thought that imaginal desensitisation, exposure, and social comparison were effective techniques.

*Treatment technique use*

For each technique, clinicians (n=13) were asked rate the proportion of their clients with gambling problems they use the technique with on a 5-point scale: (1) None or almost none; (2) fewer than half; (3) about half; (4) more than half; and (5) all or almost all. Table 6 reveals that all clinicians used goal setting, relapse prevention, information provision, motivational enhancement, and behaviour substitution with more than half or all/almost all of their clients; and nearly all clinicians used information gathering with more than half or all/almost all of their clients. In contrast, few clinicians used imaginal desensitisation, exposure, or social comparison with more than half or all/almost all of their clients.

*Treatment technique confidence*

For each technique, clinicians (n=13) were asked how confident they would be using this technique with a client with gambling problems on a 5-point scale: (1) not at all confident; (2) only slightly confident; (3) somewhat confident; (4) fairly confident; and (5) very confident. All clinicians were fairly or very confident in using goal setting, information provision, planning social support, problem solving, and self-monitoring; and nearly all clinicians were fairly or very confident in using relapse prevention, information gathering, motivational enhancement, behaviour substitution, and feedback on assessment (Table 6). In contrast, few clinicians were this confident in using imaginal desensitisation, exposure, and social comparison.

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| Table 6. Clinician perspectives on effectiveness, use and confidence of treatment techniques |
|  | Technique effectiveness (effective to very effective) | Technique use (more than half or all or almost all clients) | Technique confidence (fairly or very confident) |
| Cognitive restructuring | 13 (100%) | 11 (85%) | 11 (85%) |
| Goal setting | 13 (100%) | 13 (100%) | 13 (100%) |
| Relapse prevention | 12 (92%) | 13 (100%) | 12 (92%) |
| Information gathering | 12 (92%) | 12 (92%) | 12 (92%) |
| Information provision | 12 (92%) | 13 (100%) | 13 (100%) |
| Financial management | 12 (92%) | 8 (62%) | 11 (85%) |
| Planning social support | 12 (92%) | 11 (85%) | 13 (100%) |
| Problem solving | 11 (85%) | 11 (85%) | 13 (100%) |
| Decisional balance | 11 (85%) | 11 (85%) | 11 (85%) |
| Motivational enhancement | 11 (85%) | 13 (100%) | 12 (92%) |
| Behaviour substitution | 10 (77%) | 13 (100%) | 12 (92%) |
| Self-monitoring | 10 (77%) | 9 (69%) | 13 (100%) |
| Stimulus control | 10 (77%) | 10 (77%) | 11 (85%) |
| Feedback on assessment | 9 (69%) | 11 (85%) | 12 (92%) |
| Social skills training | 9 (69%) | 9 (69%) | 10 (77%) |
| Mindfulness | 9 (69%) | 7 (54%) | 9 (69%) |
| Imaginal desensitisation | 6 (46%) | 4 (31%) | 6 (46%) |
| Exposure | 5 (38%) | 2 (15%) | 4 (31%) |
| Social comparison | 3 (23%) | 1 (8%) | 5 (38%) |

## Appendix 6: Full list of constructs and measures - Gambling

**Full list of constructs and measures for measurement to describe people who gamble and are accessing the service**

The following table present all the constructs included in the section on measurement to describe people who gamble and are accessing the service. Acceptable measures are listed alongside an indication of whether each construct or measure was recommended for inclusion in the minimum dataset.

|  |  |  |  |
| --- | --- | --- | --- |
| **Construct** | **Acceptable measures** | **Recommended measure** | **Minimum dataset?** |
| Problem gambling activities | * GAMTOMS - Q20
 | GAMTOMS - Q20 | Y |
| Problem gambling modality | * Bespoke single item
 | Bespoke single item | Y |
| Reasons for seeking help | * Treatment Entry Questionnaire (TEQ-9)
* Survey of Treatment Entry Pressures (STEP)
 | Survey of Treatment Entry Pressures (STEP) | N |
| Prior help-seeking / attitudes to help-seeking | * Help Seeking Questionnaire (HSQ)
* Survey of Treatment Attitudes
* General Help-Seeking Questionnaire (GHSQ)
* Help-Seeking Willingness Scale (HSWS)
 | Help Seeking Questionnaire (HSQ) | N |
| Gambling harms | * Gambling Harms Scale-10 (GHS-10)/Gambling Harms Scale-20 (GHS-20) (formerly Short Gambling Harms Scale)
* 7-Item Domain-General Gambling Harm Scale
* Quilty harm measure
 | 7-Item Domain-General Gambling Harm Scale | Y |

**Full list of constructs and measures for measurement to assess risk, screen for psychiatric comorbidity, and inform referral**

The following table present all the constructs included in the screening, risk, and referral section. Acceptable measures are listed alongside an indication of whether each construct or measure was recommended for inclusion in the minimum dataset.

| **Construct** | **Acceptable measures** | **Recommended measure** | **Minimum dataset?** |
| --- | --- | --- | --- |
| Suicidal ideation | * Suicide risk item used by NZ gambling harm services and recommended by MOH
* Ask Suicide-Screening Questions
* Patient Safety Screener (PSS)
 | Suicide risk item used by NZ gambling harm services and recommended by MOH | Y |
| Family/whānau violence | * Hurt, Insult, Threaten, and Scream (HITS)
* Woman Abuse Screening Tool-Short Form (WAST-SF)
* Partner Violence Screen (PVS)
* Abuse Assessment Screen (AAS)
 | Hurt-Insulted-Threatened-Screamed (HITS) – single item adaptations for victimisation and perpetration  | Y |
| Hazardous alcohol use | * Alcohol Use Disorders Identification Test-Consumption (AUDIT-C)/Alcohol Use Disorders Identification Test-3 (AUDIT-3)
* CAGE
* T-ACE/TWEAK
* Tobacco, Alcohol, Prescription Medication, and other Substance use Tool (TAPS-Part 1) - Alcohol item
 | Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) | Y |
| 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 (TAPS-Part 1) - Prescription Medication and Other Substance use items
 | Single-Question Screening Test for Drug Use in Primary Care | Y |
| Nicotine/vaping | * Heaviness of Smoking Index
* Tobacco, Alcohol, Prescription Medication, and other Substance use Tool (TAPS-Part 1) - Tobacco item
 | Tobacco, Alcohol, Prescription Medication, and other Substance use Tool (TAPS-Part 1) - Tobacco item | N |
| Excessive gaming | * Three-Item Gaming disorder Test Online Centred (TIGTOC)
 | Three-Item Gaming disorder Test Online Centred (TIGTOC) | Y |

**Full list of constructs and measures for measurement of the impact of treatment (gambling outcomes)**

The following table present all the constructs included in the gambling treatment outcomes. Acceptable measures are listed alongside an indication of whether each construct or measure was recommended for inclusion in the minimum dataset.

| **Construct** | **Acceptable measures** | **Recommended measure** | **Minimum dataset?** |
| --- | --- | --- | --- |
| Gambling symptoms | * Gambling Symptom Assessment Scale (G-SAS)
* Problem Gambling Yale-Brown Obsessive Compulsive Scale (PG-YBOCS) - Self-Report
* Gambling Follow-up Scale (GFS-SR)
 | G-SAS | Y |
| Gambling behaviour (frequency/expenditure/duration) - via modality | * Treatment outcome profiles (TOPS)
* Global assessment items – frequency/expenditure
* GAMTOM items – frequency/expenditure items
* Gambling Follow-up Scale (GFS-SR) - frequency/expenditure items
 | Global assessment items (modified) – frequency/ expenditure | Y (frequency/ expenditure)N (duration) |
| Treatment goal attainment | * Recovery Index for Gambling Disorder (RIGD) - Gambling Reduction subscale
* Goal Attainment Scaling (GAS)
 | RIGD – Gambling Reduction Subscale | Y |

**Full list of constructs and measures for measurement of the impact of treatment (non-gambling outcomes)**

The following table present all the constructs included in the non-gambling treatment outcomes. Acceptable measures are listed alongside an indication of whether each construct or measure was recommended for inclusion in the minimum dataset.

| **Construct** | **Acceptable measures** | **Recommended measure** | **Minimum dataset?** |
| --- | --- | --- | --- |
| Psychological distress (depression and anxiety combined) | * Kessler 6 (K6)/Kessler 10 (K10)
* Recovery Index for Gambling Disorder (RIGD) - Mental Health subscale
* Symptom Checklist (SCL-5, SCL-K-9)
* Abbreviated Brief Symptom Inventory (BSI)
 | Kessler 6 K6) | N |
| Depression symptoms | * Patient Health Questionnaire (PHQ-2, PHQ-9)
* Depression Anxiety Stress Scale (DASS-21) – Depression subscale
* Hospital Anxiety and Depression Scale – Depression subscale
* Beck Depression Inventory – Short Form
 | Patient Health Questionnaire-2 (PHQ-2) | Y |
| Anxiety symptoms | * Generalised Anxiety Disorder (GAD-2, GAD-7)
* Depression Anxiety Stress Scale (DASS-21) – Anxiety subscale
* Hospital Anxiety and Depression Scale – Anxiety subscale
* Hamilton Anxiety Rating Scale
* Spielberger State-Trait Anxiety Inventory (STAI) - Short Form
 | Generalised Anxiety Disorder (GAD-2) | Y |
| Interpersonal relationships | * Recovery Index for Gambling Disorder (RIGD) - interpersonal relationships subscale
 | Recovery Index for Gambling Disorder (RIGD) - Interpersonal Relationships subscale | N |
| Functional impairment | * Recovery Index for Gambling Disorder (RIGD) - Life Functioning subscale
* WHO Disability Assessment Schedule (WHO-DAS)
* Work and Social Adjustment Scale (WSAS)
 | Work and Social Adjustment Scale (WSAS) | Y |
| Wellbeing/quality of life | * Tangata Whaiora Questionnaire – Hua Oranga
* Personal Wellbeing Index (PWI)
* WHO-5 Wellbeing Index
* EUROHIS-QOL-8
 | EUROHIS-QOL-8*Supplemented by**Tangata Whaiora Questionnaire – Hua Oranga for cultural/spirituality reasons, where appropriate* | Y |
| Recovery insight | * Recovery Index for Gambling Disorder (RIGD) - Recovery Insight subscale
 | Recovery Index for Gambling Disorder (RIGD) - Recovery Insight subscale | N |

**Full list of constructs and measures for measurement to inform treatment planning and assess processes of change**

The following table present all the constructs included in the treatment planning and process of change section. Acceptable measures are listed alongside an indication of whether each construct or measure was recommended for inclusion in the minimum dataset.

| **Construct** | **Acceptable measures** | **Recommended measure** | **Minimum dataset?** |
| --- | --- | --- | --- |
| Readiness/importance of change | * Readiness rulers: Readiness (Ready) item/Importance (Willing) item
* Volitional Scale
* Gambling Readiness to Change Questionnaire (GRTC)
* University of Rhode Island Change Assessment (URICA-12) Scale
 | Readiness rulers: Readiness (Ready) item/Importance (Willing) item | Y |
| Self-efficacy (in high-risk situations) | * Readiness rulers – Confidence (Able) item
* Brief Situational Confidence Questionnaire-Gambling
 | Readiness rulers: Confidence (Able) item | Y |
| High-risk situations | * Inventory of Gambling Situations - Short Form (IGS-10)
 | Inventory of Gambling Situations – Short Form (IGS-10) | N |
| Gambling cognitions | * Gamblers Beliefs Questionnaire – 2 subscales Luck/Perseverance (13 items) and Illusion of Control (8 items)
* Gambling Belief Questionnaire – 5 subscales ranging from belief in system (2 items) to illusion of control (7 items)
* Gambling Beliefs Questionnaire-(GBQ2) -12 subscales ranging from denial (2 items to illusion of control (9 items)
* Gambling Cognitions Inventory (GCI) - Luck and Chance subscale (14 items)
* 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 (3 items)
 | Johnson-Abbott Scale – Gambling Fallacy subscale | Y |
| Gambling urges | * Gambling Symptom Assessment Scale (G-SAS) - urge subscale
* Gambling Urge Scale
* Gambling Craving Scale
* Recovery Index for Gambling Disorder (RIGD) - urge coping subscale
* Penn Gambling Craving Scale
* Craving Experience Questionnaire – Frequency subscale
* Craving Experience Questionnaire – Strength subscale
 | Gambling Symptom Assessment Scale (G-SAS) - urge subscale | Y |
| Gambling motives | * Gambling Motives Questionnaire (GMQ)
* Gambling Motives Questionnaire-Financial (GMQ-F)
* Gambling Passions Scale – Short Form
* Reasons for Gambling Scale
 | Gambling Motives Questionnaire-Financial (GMQ-F) | N |

The following table present all the constructs included in the treatment planning and process of change section. Acceptable measures are listed alongside an indication of whether each construct or measure was recommended for inclusion in the minimum dataset.

| **Construct** | **Acceptable measures** | **Recommended measure** | **Minimum dataset?** |
| --- | --- | --- | --- |
| Client satisfaction | * Client Satisfaction Questionnaire
* Service Evaluation Questionnaire
* Client satisfaction questionnaire (CSQ-8)
 | Client Satisfaction Questionnaire | Y |
| Session satisfaction | * Session Rating Scale (SRS)
* Session Impacts Scale (SIS)
 | Session Rating Scale (SRS) | N |
| Therapeutic relationship | * Working Alliance Inventory-Short Form
* The Individual Therapy Alliance Scale Revised—Short Form (ITASr-SF)
 | Working Alliance Inventory-Short Form | N |

## Appendix 7: Full list of constructs and measures - Affected others

**Full list of constructs and measures for measurement to describe affected others who are accessing the service**

The following table present all the constructs included in the section on measurement to describe affected others who are accessing the service. Acceptable measures are listed alongside an indication of whether each construct or measure was recommended for inclusion in the minimum dataset.

| **Construct** | **Acceptable measures** | **Recommended measure** | **Minimum dataset?** |
| --- | --- | --- | --- |
| Relationship to the person who gambles | * Pre-amble to the Gambling Harm Scale-10 for Affected Others (GHS-10-AO)
* Single items measuring lifetime or current exposure to problem gambling or harm from gambling across all different relationships
 | Pre-amble to the Gambling Harm Scale-10 for Affected Others (GHS-10-AO) | Y |
| 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
* Inventory of Consequences Scale (ICS) - CSO Behavioural Consequences subscale
* Gambling Harm Scale-10-Affected Others (GHS-10-AO)
* Short Questionnaire for Family Members Affected by Addiction – Psychological Symptoms subscale
* Short Questionnaire for Family Members Affected by Addiction – Physical Symptoms subscales
 | The Gambling Harm Scale-10 for Affected Others (GHS-10-AO) | Y |
| Reasons for seeking help | * Reasons for Family Help-Seeking Checklist (13 items)
 | Reasons for Family Help-Seeking Checklist (13 items) | N |
| Prior help-seeking / attitudes to help-seeking | * Help-Seeking Questionnaire (HSQFam)
* Survey of Treatment Attitudes
* General Help-Seeking Questionnaire (GHSQ)
* Help-Seeking Willingness Scale (HSWS)
 | Help-Seeking Questionnaire (HSQFam) | N |

**Full list of constructs and measures for measurement to assess risk, screen for psychiatric comorbidity, and inform referral**

The following table present all the constructs included in the screening, risk, and referral section. Acceptable measures are listed alongside an indication of whether each construct or measure was recommended for inclusion in the minimum dataset.

| **Construct** | **Acceptable measures** | **Recommended measure** | **Minimum dataset?** |
| --- | --- | --- | --- |
| Suicidal ideation | * Suicide risk item used by NZ gambling harm services and recommended by MOH
* Ask Suicide-Screening Questions
* Patient Safety Screener (PSS)
 | Suicide risk item used by NZ gambling harm services and recommended by MOH | Y |
| Family/whānau violence | * Hurt, Insult, Threaten, and Scream (HITS)
* Woman Abuse Screening Tool-Short Form (WAST-SF)
* Partner Violence Screen (PVS)
* Abuse Assessment Screen (AAS)
 | Hurt-Insulted-Threatened-Screamed (HITS) – single item adaptations for victimisation and perpetration  | Y |
| Hazardous alcohol use | * Alcohol Use Disorders Identification Test-Consumption (AUDIT-C)/Alcohol Use Disorders Identification Test-3 (AUDIT-3)
* CAGE
* T-ACE/TWEAK
* Tobacco, Alcohol, Prescription Medication, and other Substance use Tool (TAPS-Part 1) - Alcohol item
 | Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) | Y |
| 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 (TAPS-Part 1) - Prescription Medication and Other Substance use items
 | Single-Question Screening Test for Drug Use in Primary Care | Y |
| Nicotine/vaping | * Heaviness of Smoking Index
* Tobacco, Alcohol, Prescription Medication, and other Substance use Tool (TAPS-Part 1) - Tobacco item
 | Tobacco, Alcohol, Prescription Medication, and other Substance use Tool (TAPS-Part 1) - Tobacco item | N |
| Own gambling symptoms | * One-Item Screen
* Brief Problem Gambling Screen (BPGS) (2-5 item versions
* Lie/Bet Questionnaire
* Brief Biosocial Gambling Screen (BBGS)
* Consumption Screen for Problem Gambling (CSPG)
* National Opinion Research Center Diagnostic Screen for Gambling Disorders – Loss of Control, Lying and Preoccupation (NODS-CliP/NODS-CLIP2)
* Problem Gambling Severity Index – Short Form (PGSI-SF)
* Rapid Screener for Problem Gambling (self-assessment version) (RSPG-SA)
* National Opinion Research Centre Diagnostic Screen for Gambling Disorders – Preoccupation, Escape, Chasing, and Risked Relationships (NODS-PERC)
* Short South Oaks Gambling Screen (Short SOGS)
 | One-Item Screen | Y |

**Full list of constructs and measures for measurement of the impact of treatment (affected other focused)**

The following table present all the constructs included in the affected other focused treatment outcomes. Acceptable measures are listed alongside an indication of whether each construct or measure was recommended for inclusion in the minimum dataset.

| **Construct** | **Acceptable measures** | **Recommended measure** | **Minimum dataset?** |
| --- | --- | --- | --- |
| Psychological distress (depression and anxiety combined) | * Kessler 6 (K6)/Kessler 10 (K10)
* Short Questionnaire for Family Members Affected by Addiction – Psychological Symptoms subscale
* Symptom Checklist (SCL-5, SCL-K-9)
* Abbreviated Brief Symptom Inventory (BSI)
 | Kessler 6 K6) | N |
| Depression symptoms | * Patient Health Questionnaire (PHQ-2, PHQ-9)
* Depression Anxiety Stress Scale (DASS-21) – Depression subscale
* Hospital Anxiety and Depression Scale – Depression subscale
* Beck Depression Inventory – Short Form
 | Patient Health Questionnaire-2 (PHQ-2) | Y |
| Anxiety symptoms | * Generalised Anxiety Disorder (GAD-2, GAD-7)
* Depression Anxiety Stress Scale (DASS-21) – Anxiety subscale
* Hospital Anxiety and Depression Scale – Anxiety subscale
* Hamilton Anxiety Rating Scale
* Spielberger State-Trait Anxiety Inventory (STAI) - Short Form
 | Generalised Anxiety Disorder (GAD-2) | Y |
| Stress symptoms | * Perceived Stress Scale-4 (PSS-4)
* Single Item Measure of Stress Symptoms
 | Perceived Stress Scale-4 (PSS-4) | Y |
| Interpersonal relationships | * Recovery Index for Gambling Disorder (RIGD) - interpersonal relationships subscale
 | Recovery Index for Gambling Disorder (RIGD) - Interpersonal Relationships subscale | N |
| Functional impairment | * WHO Disability Assessment Schedule (WHO-DAS)
* Work and Social Adjustment Scale (WSAS)
 | Work and Social Adjustment Scale (WSAS) | Y |
| Physical health | * Short Questionnaire for Family Members Affected by Addiction – Physical Symptoms subscale
 | Short Questionnaire for Family Members Affected by Addiction – Physical Symptoms subscale | N |
| Wellbeing/quality of life | * Tangata Whaiora Questionnaire – Hua Oranga
* Personal Wellbeing Index (PWI)
* WHO-5 Wellbeing Index
* EUROHIS-QOL-8
 | EUROHIS-QOL-8*Supplemented by**Tangata Whaiora Questionnaire – Hua Oranga for cultural/spirituality reasons, where appropriate* | Y |

**Full list of constructs and measures for measurement of the impact of treatment (gambler focused)**

The following table present all the constructs included in the non-gambling treatment outcomes. Acceptable measures are listed alongside an indication of whether each construct or measure was recommended for inclusion in the minimum dataset.

|  |  |  |  |
| --- | --- | --- | --- |
| **Construct** | **Acceptable measures** | **Recommended measure** | **Minimum dataset?** |
| Gambling support self-efficacy | * Caregiving Self-Efficacy Scale-8 (CSES-8)
 | Caregiving Self-Efficacy Scale-8 (CSES-8) | Y |

**Full list of constructs and measures for measurement to inform treatment planning and assess processes of change**

The following table present all the constructs included in the treatment planning and process of change section. Acceptable measures are listed alongside an indication of whether each construct or measure was recommended for inclusion in the minimum dataset.

|  |  |  |  |
| --- | --- | --- | --- |
| **Construct** | **Acceptable measures** | **Recommended measure** | **Minimum dataset?** |
| Coping | * Brief-COPE – Adaptive (Active Coping and Planning Coping subscales); Maladaptive (Self-Blame and Behavioural Disengagement subscales)
* Short Questionnaire for Family Members Affected by Addiction –Coping Questionnaire (CQ)
 | Brief-COPE – Adaptive (Active Coping and Planning Coping subscales); Maladaptive (Self-Blame and Behavioural Disengagement subscales) | Y |
| Social support | * Brief-COPE – Emotional Support and Instrumental Support subscales
* Brief Social Support Scale (BSS6)
* Perceived Social Support Questionnaire (F-SozU)
 | Brief Social Support Scale (BSS6) | Y |

**Full list of constructs and measures for measurement of client satisfaction**

The following table present all the constructs included in the treatment planning and process of change section. Acceptable measures are listed alongside an indication of whether each construct or measure was recommended for inclusion in the minimum dataset.

|  |  |  |  |
| --- | --- | --- | --- |
| **Construct** | **Acceptable measures** | **Recommended measure** | **Minimum dataset?** |
| Client satisfaction | * Client Satisfaction Questionnaire
* Service Evaluation Questionnaire
* Client satisfaction questionnaire (CSQ-8)
 | Client Satisfaction Questionnaire | Y |
| Session satisfaction | * Session Rating Scale (SRS)
* Session Impacts Scale (SIS)
 | Session Rating Scale (SRS) | N |
| Therapeutic relationship | * Working Alliance Inventory-Short Form
* The Individual Therapy Alliance Scale Revised—Short Form (ITASr-SF)
 | Working Alliance Inventory-Short Form | N |