APS Australian Psychological Society

PRACTICE GUIDE

Psychological care for people experiencing gambling harm

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to their Elders, past, present and emerging, for they hold the dreams of Indigenous Australia.

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Section 1: Context

Gambling disorder is an addictive disorder, similar to substance use disorders, defined in the DSM-5-TR by persistent or recurrent gambling over 12-months which leads to clinically significant impairment or distress, with diagnostic criteria including behavioural dependence symptoms (e.g., tolerance, withdrawal) and adverse consequences.

Problem gambling includes both dependence symptoms and adverse consequences, but no impairment or distress. The term ***gambling harm*** is now preferred because it reduces stigma by focusing on broader determinants and impacts, despite focusing only on adverse consequences. This guide recognises differing views on terminology by diverse stakeholders and uses the term *harmful gambling*. Harmful gambling arises from multiple interacting factors, as explained by the biopsychosocial, syndrome, and pathways models.

The Conceptual Framework of Harmful Gambling identifies both gambling-specific (gambling environment, exposure, types, resources) and general (cultural, psychological, social, biological) determinants. In Australia, 0.4%-1.2% of adults experience problem gambling, 1.9%-37% experience moderate-risk gambling, and 3.0%-7.7% experience low-risk gambling, with young men most at-risk. Similarly, 1.5% of adolescents report problem gambling and an additional 2.2% report at-risk gambling. Gambling often begins in childhood, with earlier onset linked to more severe symptoms. While relapse is common, gambling is generally not progressive, enduring, or unremitting. Psychiatric comorbidities, such as mood, alcohol use, and personality disorders, are common in treatment-seeking gamblers. Harmful gambling is also linked to intimate partner and family violence, suicidal ideation and attempts, and harmful gaming.

1.1 Definitions

Gambling disorder

Gambling disorder was the first behavioural addiction with sufficient evidence to be included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) or international Classification of Diseases (ICD-9). At that time, *Pathological Gambling was classified as an Impulse Control Disorder in the DSM-III* and a *Habit and Impulse Disorder* in the ICD-9. *Gambling disorder* is now classified as a *Substance-Related and Addictive Disorder* in the DSM-5 and a Disorder Due to Addictive Behaviours in the ICD-11, based on evidence that it shares similarities to alcohol and other substance use disorders in terms of diagnostic criteria, phenomenology, clinical characteristics, comorbidities, personality and neurocognitive features, biochemistry, neurocircuitry, genetic underpinnings, and treatments.[1,2]

In the DSM-5-TR[3], *gambling disorder* (312.31; F63.0) is defined as "persistent and recurrent problematic gambling behaviour leading to clinically significant impairment or distress" that is not better explained by a manic episode. The individual must exhibit four (or more) of the following in a 12-month period:

- needing to gamble with increasing amounts of money in order to achieve the desired excitement;
- is restless or irritable when attempting to cut down or stop gambling;
- has made repeated unsuccessful effort to control, cut back, or stop gambling;
- is often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble);
- often gambles when feeling distressed (e.g., helpless, guilty, anxious, depressed);
- after losing money gambling, often returns another day to get even ("chasing" one's losses);
- lies to conceal the extent of involvement with gambling;
- has jeopardised or lost a significant relationship, job, or educational or career opportunity because of gambling;
- relies on others to provide money to relieve desperate financial situations caused by gambling.

Several specifiers can be applied to this diagnosis in terms of:

- **Chronicity:** Episodic (symptoms subside for several months between episodes) and persistent (continuous symptoms for multiple years).
- **Remission:** In early remission (criteria not met for 3-12 months) and in sustained remission (criteria not met for 12+ months).
- **Current severity:** Mild (4 or 5 criteria met), moderate (6 or 7 criteria met), and severe (8 or 9 criteria met).

In the ICD-11,[4] *gambling disorder* (6C50) is defined by a "pattern of persistent or recurrent gambling behaviour", which may be predominantly offline (6C50.0), predominantly online (6C50.1) or unspecified (6C5.0.Z). Diagnostic criteria include: (1) impaired control over gambling; (2) increasing priority given to gambling to the extent that gambling takes precedence over other life interests and daily activities; and (3) continuation or escalation of gambling despite the occurrence of negative consequences. Gambling may be continuous or episodic and recurrent, causing significant distress or impairment in functioning. The diagnosis requires symptoms to persist for at least 12 months, although a shorter duration is possible with severe symptoms. Exclusionary criteria include Bipolar Disorders and *Hazardous Gambling or Betting* (QE21), which refers to "a pattern of gambling or betting that appreciably increases the risk of harmful physical or mental health consequences to the individual or to others around the individual", thereby acknowledging that harm can occur when diagnostic criteria are not met.

Problem gambling

In Australia, the public health perspective shifted the preferred terminology to *problem gambling*, whereby gambling is viewed across a continuum of risk (low-risk, moderate-risk and problem gambling).[5] Problem gambling is defined as "difficulties in limiting money and/or time spent on gambling, which leads to adverse consequences for the gambler, others or for the community".[6] Like the diagnosis, problem gambling comprises both behavioural dependence symptoms (e.g., tolerance, withdrawal, preoccupation, chasing) and adverse consequences, but unlike the diagnosis, it does not require clinically significant impairment or distress.

Gambling harm

More recently, the term *problem gambling* has shifted to *gambling harm*, despite only focussing on adverse consequences. In Australia, gambling harm refers to any initial or exacerbated adverse consequence due to gambling engagement that leads to significant decrements to the health or wellbeing of individuals, families, communities or populations.[7] A harm taxonomy[7] identifies seven dimensions of harm: financial, emotional, relationship, physical health, work performance, cultural, and criminal.

These harms occur across three temporal categories: general harms (occurring after gambling starts), crisis harms (occurring at significant moments), and legacy harms (long-term harms occurring even after gambling ends). People with problem gambling experience more harm, but moderate- and low-risk gambling contribute most to population-level harm due to their higher prevalence.[8]

The term *gambling harm* is preferred by many over *problem gambling* to reduce stigma by shifting the focus from individual determinants to social, cultural, policy, economic, environmental, and industry factors and reflecting the broader impacts of gambling on individuals, families, and communities. Aligned with public health perspectives, the term *gambling harm* emphasises prevention, mitigation, and societal-level interventions. Using this term instead of *problem gambling* or *gambling disorder*, however, presents challenges in many research and clinical contexts,[9] including measurement inconsistencies, difficulty interpreting past studies, and imprecise language for future research. This shift reduces diagnostic precision, undermines clinical validity, removes the benefits of diagnostic labels, and diverts focus from individual pathology, which helps explain vulnerability and guide interventions. Ironically, conflating the condition with its harms also contradicts the public health approach by blurring the distinction between determinants, conditions, and consequences.

Adoption of terminology

The terms *gambling disorder* or *problem gambling* may be used in clinical, diagnostic and, research contexts where specificity is needed, while *gambling harm* can be used in public health discussions focussing on broader societal impacts, prevention, and community or systemic interventions. This practice guide acknowledges that there is no one-size-fits all approach for describing issues related to gambling and that people with lived experience of gambling harm have varied reactions to different terms.[10] It encourages the adoption of a non-stigmatising and humanising approach using person-first language (e.g., person experiencing gambling harm) and avoiding identity-first language (e.g., problem gamblers).[10] Clinicians should also consider the preferred terminology of their clients when considering terminology. The term *harmful gambling*, which has been used to refer to "any type of repetitive gambling that a person engages in that leads to (or aggravates) recurring negative consequences, such as significant financial problems, addiction, or physical and mental health issues"[11] will be used in this guide, with person-first language, except in contexts where specificity is essential.

1.2 Aetiology

Various theoretical models attempt to account for the development and maintenance of harmful gambling. These include single-domain models, such as:

- **Biological models:** gambling is influenced by genetic predispositions, neurotransmitter imbalances, and brain structure abnormalities, particularly involving the reward system, impulse control, and dopamine regulation.
- **Psychoanalytic models:** gambling is driven by unconscious conflicts, repressed desires, and unresolved childhood experiences, often linked to issues of impulse control and seeking gratification.
- **Behavioural models:** gambling is learned and reinforced through operant conditioning, such as intermittent wins, excitement, and escape from negative emotions; and classical conditioning, whereby neutral cues become associated with excitement.
- **Cognitive models:** gambling is influenced by distorted thinking patterns, such as overestimating the likelihood of winning, believing in personal control over outcomes, and engaging in rationalisations.

These single-domain models cannot account for the complex interaction of risk and protective factors implicated in harmful gambling. Biopsychosocial models and the syndrome model of addiction take these complex interactions into consideration:

- **Biopsychosocial models:** Biopsychosocial models are therefore often used, which include biological, personality, cognitive, environmental, and cultural determinants, along with life stressors, psychological issues, and gambling-related risks.[12]
- **Syndrome model of addiction:** The Syndrome Model of Addiction[13] suggests that addiction is a complex condition with varying symptoms and behaviours that manifest in different ways depending on the substance or behaviour, but that all share common underlying vulnerabilities resulting from the interaction of biological, psychological, and social factors.

These models are unable to explain the heterogeneity of people experiencing harmful gambling, which lead to the development of the Pathways model.[14]

Pathways model

Supported by research evidence[15], this influential model suggests that ecological factors such as gambling availability, operant conditioning, cognitive distortions, and chasing losses affect all individuals but that distinct aetiological factors distinguish the gambling trajectories of three subgroups:

- **Pathway 1: "Behaviourally conditioned" subgroup.** This subgroup begins gambling socially after exposure to gambling but then alternates between heavy and harmful gambling due to operant conditioning, cognitive distortions, or poor decision-making rather than impaired control. They exhibit mild symptoms, mainly preoccupation and chasing losses, and may develop mental health conditions or alcohol abuse consequent to gambling. Highly motivated for treatment, they respond well to counselling and minimal interventions.
- **Pathway 2: "Emotionally vulnerable" subgroup.** This subgroup shares the same determinants and cognitive patterns, but often have pre-existing mental health issues, poor coping, and family difficulties. They gamble to alleviate distress, but this exacerbates their psychopathology. They are more resistant to change and require treatment addressing both gambling and underlying vulnerabilities.
- **Pathway 3: "Antisocial impulsivist" subgroup.** This subgroup resembles Pathway 2 but with greater impulsivity, risk-taking, antisocial traits, and attentional deficits. They often have substance abuse, suicidal ideation, irritability, boredom intolerance, sensation seeking, and social difficulties, but low anxiety and depression. They gamble to cope with stress and search for meaning. Gambling starts early, escalates quickly, and often involves binge episodes. They rarely seek or respond well to treatment.

The revised Pathways model[16] maintains similar subtypes but distinguishes Pathway 3 from Pathway 2. Pathway 2 gamblers are characterised by childhood maltreatment and stress-coping gambling, while Pathway 3 gamblers display higher risk-taking, antisocial traits, and gambling to find meaning or alleviate stress.

Evidence-based risk and protective factors

Multiple factors collectively and additively contribute to the development of harmful gambling,[17,18] with most focus on individual risk factors and less on protective factors or relationship, community, or societal risk factors. The strongest risk factors include "gambling-related" variables (e.g., "problem gambling" status, gambling involvement, gambling fallacies, and social gambling environments), impulsivity, addiction propensity, mental health issues, lower income, male gender, and younger age.

The Conceptual Framework of Harmful Gambling,[11] developed by international experts, outlines gambling-specific and general determinants supported by research evidence. Gambling-specific factors include:

- **Gambling environment:** The social and political gambling environment influences gambling opportunities, behaviour, and harm, including government policy and regulation, harm reduction practices, and social responsibility. This includes the online gambling environment.[19]
- **Gambling exposure:** Exposure to gambling, including factors such as setting, availability, advertising and marketing and gambling-like gaming, influences the likelihood of harmful gambling.
- **Gambling types:** Certain types of gambling, like pokies, sports betting, and casino table games, have greater potential for harm. Key factors include structural characteristics, multiple gambling activities, and reasons for gambling.
- **Gambling resources:** Gambling resources include prevention programs and treatments to reduce harms. In Australia, various resources are available for harm reduction, prevention, support, and treatment.

In contrast, general factors resemble the factors included in biopsychosocial models, such as:

- **Cultural factors:** Cultural factors can affect gambling behaviour, attitudes, and harm, including aspects such as ethnicity and traditions, socio-cultural attitudes, religion, indigenous peoples, and gambling cultures (see Section 4.1 for information on people from diverse communities).
- **Psychological factors:** Individual psychological factors that increase vulnerably to harmful gambling include mental health issues, alcohol and drug use, false beliefs, traumatic childhood experiences, antisocial behaviour, coping styles, personality traits, subjective wellbeing, and resilience.
- **Social factors:** Social factors influencing gambling availability and related harm include demographic characteristics (e.g., younger age, male gender), family and friend influences, and social support.
- **Biological factors:** Biological factors, such as genetics and biological differences in brain structure and functioning (e.g., traumatic brain injuries), increase susceptibility to harmful gambling (also see Section 4.1 for information on people using dopamine agonist medications).

1.3 Prevalence

Nationally, problem gambling affects between 0.4% to 1.2% of adults, with an additional 1.9% to 3.7% reporting moderate-risk gambling and 3.0% to 7.7% reporting low-risk gambling.[20-22] In NSW,[23] 53.5% of adults gambled in the past year and 27% did so online. Men were more than twice as likely as women to experience problem or moderate-risk gambling. Young men aged 18-24 years were most at-risk. Gambling harm in the past year was reported by 7.8% of adults and legacy harms were reported by 7.1%. Among NSW youth aged 12-17,[24] 29.8% gambled in the past year. Overall, 1.5% of youth reported problem gambling and an additional 2.2% reported at-risk gambling.

1.4 Onset, course and prognosis

Age of first gambling. Internationally, first gambling experiences typically occur between ages 10 and 19,[25] with earlier first gambling associated with more severe gambling symptoms.[26] In NSW, the average age of first gambling for youth aged 12 and 17 is 11.[24]

Typical course and prognosis

Historically, harmful gambling was seen as progressive, enduring and unremitting, but research evidence shows this is not the case.[18] Most people with subclinical harmful gambling improve over time, subclinical symptoms are a poor predictor of future issues, and only a small proportion of people experience an unremitting course. There considerable variability in trajectories, with some people having a chronic course, others remitting after a single episode, and others transitioning in and out of harmful

gambling. However, risk of relapse is common, with between one-third to one-half of those who remit relapsing within two or three years. The severity of symptoms, the duration of the existing episode, and whether significant comorbidities are present are key factors influencing chronicity.

1.5 Psychiatric comorbidities and associated risks

Psychiatric comorbidities

Psychiatric comorbidities are common in harmful gambling, with systematic review evidence suggesting that three-quarters (74.8%) of treatment-seeking gamblers reporting clinical disorders, primarily mood disorders (23.1%) and alcohol use disorders (21.2%).[27] The most common are nicotine dependence (56.4%), major depressive disorder (29.9%) and alcohol abuse (18.2%), with smaller proportions (11.5-15.2%) experiencing alcohol dependence, social phobia, generalised anxiety disorder, panic disorder, post-traumatic stress disorder (PTSD), and cannabis use disorder. Similarly, personality disorders are reported by half (47.9%) of treatment-seeking gamblers, with the most common being narcissistic (16.6%) and antisocial (14.0%) personality disorders, as well as avoidant, obsessive-compulsive, and borderline (13.1-13.4%).[28]

Other non-diagnostic associated risks

Harmful gambling has also been consistently linked to other non-diagnostic associated risks, including:

- **Intimate partner and family violence:** Harmful gambling is linked to intimate partner and family violence,[29] with about one-third of Australians seeking treatment for gambling (33.9%) also experiencing and/or perpetrating family violence.[30] Financial abuse is also common, with some gamblers controlling family finances for gambling and some family members restricting their financial access to manage family finances.[31] Explanations for the link between gambling and family violence[32] include gambling losses fuelling anger and frustration, leading to violence, and the stress caused by gambling worsening relationship tensions. Gambling may also interact with other co-morbidities, such as substance use and mental health issues, which can exacerbate violence. Additionally, gambling can reinforce existing patterns of controlling behaviour and gender inequality, particularly in relationships with male partners. While gambling can contribute to family violence, it is often one factor among many, and the role it plays can vary depending on the circumstances and type of violence.
- **Suicidal ideation and attempts:** Suicidal ideation and attempts are more common in people with harmful gambling, with 31.6% experiencing suicidal ideation and 13.2% reporting suicide attempts in their lifetimes.[33]
- **Gaming:** Finally, people with harmful gaming are also more likely to gamble, with 40.1% of young people in Australia playing games that have gambling components,[24] including:
  - *Gambling on skins:* Virtual items that can change the appearance of avatars.
  - *Purchasing loot boxes:* Virtual treasure chests that can be opened in a game containing random items that can help players advance in the game or be used for cosmetic reasons.
  - *Betting on fantasy sports:* Structured online competitions in which players compete by assembling a virtual team of players of a professional sport, and
  - *Betting on e-sports:* Competitions between skilled gamers or gaming teams who play for money and prizes.

Section 2: Screening and assessment

Clinical guidelines advise non-specialist healthcare providers ask about gambling, use direct questions, employ validated screening and assessment tools, and refer to specialists when needed.

In specialist settings, they recommend using validated tools, assessing various gambling-related factors, and creating a care and safety plan. Measures should be chosen based on their purpose, including screening and assessment, diagnosis, and treatment outcome monitoring. Several brief screening tools (1-5 items) effectively detect problem and at-risk gambling, including the NODS-PERC (4 items) and NODS-CLiP (3 items). Shorter options include the Lie/Bet Questionnaire (2 items) and the One-Item Screen. Longer assessments of symptom severity include the Problem Gambling Severity Index (limited in specialist settings), gambling disorders Identification Test, National Opinion Research Center Diagnostic Screen for Gambling Problems, and Sydney Laval Universities Gambling Screen. The gold standard for diagnosis is a clinician-administered structured clinical interview, such as the Structured Clinical Interview for gambling disorder. Treatment outcome monitoring should assess intended outcomes, such as gambling behaviour (e.g., global single items), gambling symptom severity (e.g., Gambling Symptom Assessment Scale), processes of change (e.g., readiness to change, self-efficacy, gambling cognitions, urges), and recovery (e.g., Recovery Index for gambling disorder). Gambling harm can be assessed with the Gambling Harms Scale-10 or the Domain-General Gambling Harm Scale. Clinicians are encouraged to screen for urgent issues related to harmful gambling, including suicidal ideation and family violence, that may require immediate treatment or referral. gambling disorder must be differentiated from non-disordered gambling, manic episodes, personality disorders, or other medical conditions.

2.1. Clinical guidelines for screening and assessment

Assessment guidelines for non-specialist healthcare providers

The draft UK National Institute for Health and Care Excellence (NICE) guidelines[34] recommend that non-specialist healthcare providers screen for gambling during health checks or service registration, especially alongside other risk factors like mental health issues, addiction, financial concerns, medications (e.g., dopamine agonists), neurological conditions, or certain occupations (e.g., military, gambling industry). Providers should recognise cumulative risk factors, use direct questions, and assess symptom severity. The earlier Australian National Health and Medical Research Council (NHMRC) guidelines[35] made a consensus-based recommendation based on clinical opinion and expertise that people who screen positive for harmful gambling in these settings, particularly those with mental health issues, are referred to trained specialist practitioners for further assessment and treatment.

Assessment guidelines for specialist providers

These guidelines also recommend specialist providers use a validated tool to assess gambling symptom severity, along with a comprehensive evaluation of gambling history, frequency, financial impacts, types of gambling, associated harms, contributing factors, motivations, diagnostic criteria, reasons for seeking support, readiness to change, treatment expectations and goals, suicide risk, safeguarding concerns, medical history, and immediate needs. Based on this assessment, a case formulation, care plan, and safety plan (if needed) should be developed.

2.2. Selecting measures

In the clinical management of harmful gambling, screening/assessment, diagnosis, and treatment outcome monitoring[36] are distinct but interconnected processes that are integral to delivering effective psychological care. Instruments often used interchangeably and sometimes inappropriately for these purposes, which complicates clinical care, highlighting the need for a structured approach to selecting instruments that align with their intended purpose.

2.3. Measures for screening and assessment

Screening is encouraged in clinical settings with a high likelihood of gambling harms among clients presenting for treatment, such as general practices, mental health services, alcohol and other drug services, and family violence services.

Brief instruments (1-5 items)

Several brief screening tools effectively detect both problem and at-risk gambling in various settings: Brief Problem Gambling Screen (BPGS-2), NODS-CLiP, Problem Gambling Severity Index-Short Form (PGSI-SF), NODS-PERC, and NODS-CLiP2.37 Of these, the 3-item NODS-CLiP38 and 4-item NODS-PERC39 are the most evaluated, with the NODS-CLiP potentially having an advantage due to its shorter length and better detection of at-risk gambling in the general population. The 2-item Lie/Bet Questionnaire40 and the One-Item Screen[41] (“Have you ever had an issue with your gambling?”) are also promising instruments for services requiring shorter tools.

Longer instruments (6+ items)

In addition to brief screening tools, longer screening and/or assessment tools are available to assess the severity of gambling symptoms.[36] The 9-item PGSI42 is the most validated and widely used in Australian gambling prevalence surveys but has limited clinical utility in specialist gambling settings as it was developed for use in the general population and most clients score in the problem gambling category. However, a refined cut-off of 18 helps to distinguish between low and high problem gambling severity.[43]

Some alternatives are based on diagnostic criteria, including the gambling disorders Identification Test (G-DIT) and the National Opinion Research Center Diagnostic Screen for Gambling Problems (NODS). The 14-item G-DIT,[44] which is aligned with the Alcohol Use Disorders Identification Test (AUDIT), assesses gambling behaviour, gambling symptoms, and negative consequences, with cut-off scores corresponding to recreational, problem gambling, and any gambling disorder, as well as mild, moderate, and severe gambling disorder. The 17-item NODS,[45] and its updated version (NODS-GD, aligned with DSM-5),[46] both evaluate gambling behaviours and symptoms and has been particularly effective in identifying more severe cases of gambling disorder in clinical settings. The 7-item Sydney Laval Universities Gambling Screen (SLUGS) is also a useful brief single-purpose measure specifically developed to screen for harmful gambling by identifying impaired control and subjective harm, as well as self-reported need for treatment.[47]

2.4. Measures for diagnosis

Few diagnostic instruments are available for the diagnosis of gambling disorder.[36] The gold standard is the clinician-administered structured clinical interview, which includes the Structured Clinical Interview for Pathological Gambling (SCI-PG), a widely recognised, clinician-administered instrument developed based on DSM-IV criteria to robustly diagnose gambling disorder in a clinical setting. Its updated version, the Structured Clinical Interview for gambling disorder (SCI-GD), aligns with DSM-5 criteria, diagnosing gambling disorder if four or more criteria are met, with thresholds for mild, moderate, and severe gambling disorder.

2.5. Measures for treatment outcome monitoring

Optimal treatment outcome measurement for gambling reflects the aims of treatment (intended outcomes), the therapeutic targets of the intervention (processes of change), and outcomes beyond those relating to basic reductions in gambling symptoms (recovery outcomes). The Banff consensus,[48] which was an early expert panel consensus, indicated the proposed minimum features of treatment outcome evaluation include measures reflecting changes in gambling behaviour, gambling symptom severity, the processes of change driving therapeutic change.

Intended outcomes

Intended outcomes can include gambling behaviour and gambling symptom severity, which can be supplemented by other intended outcomes specific to the intervention (e.g., psychological distress, depression, anxiety).

Gambling behaviour

Despite commonly being used as a treatment outcome measure, there is no standardised measure of gambling behaviour (frequency, expenditure, duration), with research and clinical services using their own versions of global assessment items. While the TimeLine Followback method[49] is best practice, it requires training and significant administration time. Recent evidence also suggests that its accuracy for measuring expenditure is no better than a single-item global measure.[50] Global assessment items should: (1) separate out behaviour based on gambling modality (e.g., land-based, online); (2) use "number of days" for gambling frequency given it is difficult for many online gamblers to track how often they bet; and (3) employ best-practice descriptions of gambling expenditure to ensure reliable data.

Gambling symptom severity

Most gambling screening or assessment tools are unsuitable for treatment outcome measures as they were developed to estimate past-year prevalence in the general population. For example, the PGSI is unsuitable for measuring treatment outcomes as it was not developed for this purpose, has a 12-month timeframe, and does not adequately discriminate between treatment-seeking gamblers. Few instruments have been specifically developed to measure changes in symptom severity over time.[36] Most widely used is the Gambling Symptom Assessment Scale (G-SAS),[51] a reliable and valid instrument measuring gambling symptoms over the past 7 days, with cut-off scores indicating extreme, severe, moderate, mild and minimal symptoms.

Processes of change

Various constructs can serve as processes of change depending on the treatment and aid in treatment planning, including gambling cognitions, urges, readiness to change, self-efficacy, coping, social support, emotion dysregulation, distress tolerance, mindfulness, and acceptance. For example, motivational interviewing (MI) could measure readiness to change and self-efficacy, while cognitive-behavioural treatments (CBT) could measure gambling cognitions and urges.

Recovery outcomes

Recovery has evolved from being solely defined by symptom remission to a broader, holistic process focused on achieving optimal health, functioning, and wellbeing. Recovery is seen as dynamic and individualised, addressing not only gambling reduction, but also insight into underlying factors and building a meaningful life beyond gambling. The emphasis is on long-term maintenance of these improvements, recognising that recovery is a continuous, nonlinear process that may involve setbacks such as relapse. The 32-item Recovery Index for gambling disorder (RIGD)[52] has been developed to measure this broader recovery, with subscales measuring gambling reduction, urge coping, recovery wisdom, life functioning, interpersonal relationships, and mental health.

2.6. Broader assessment of gambling-related harms

Gambling harm is not an appropriate treatment outcome measure as it tends to lag behind changes in gambling behaviour and can persist well after gambling behaviour ceases. The 10-item Gambling Harms Scale-10 (GHS-10, formerly the Short Gambling Harms Scale),[53] which measures harm in the previous year, is the most widely validated and used measure. However, because the items do not provide coverage of all harm domains, the 7-item Domain-General Gambling Harm Scale (DGHS-7)[54] can be used when measurement of each harm domain is required.

2.7. Screening for urgent issues associated with harmful gambling

Clinicians are also encouraged to screen for urgent issues associated with harmful gambling that may require immediate treatment or referral, such as suicidal ideation, family violence, hazardous alcohol use, other drug use, gaming, depression, and anxiety. For example, the 12-item Composite Abuse Scale (Revised) – Short form is a comprehensive brief instrument capturing the severity and intensity of physical, sexual, and psychological abuse,[55] while the 14-item Revised Scale of Economic Abuse provides a dedicated screen for economic restriction and economic exploitation.[56]

2.8. Differential diagnosis

Gambling disorder must be distinguished from several other conditions and disorders, including:

- **"Professional" or "social" gambling:** Non-disordered gambling may include "professional gambling", in which risks are limited and discipline is central, and "social gambling", which generally occurs with friends or colleagues, has a short duration, and involves acceptable losses.
- **Manic episodes:** Gambling disorder is diagnosed only if excessive gambling occurs outside manic episodes, as these episodes can involve excessive gambling.
- **Personality disorders:** People with personality disorders, especially antisocial personality disorder, can also be diagnosed with gambling disorder if the criteria for disorders are met.
- **Other medical conditions:** Increased gambling may occur in people prescribed dopaminergic medications (e.g., for Parkinson's disease), but a gambling disorder diagnosis is not warranted if the behaviour decreases when the medication is reduced or stopped.

Section 3: Treatment

Specialist gambling harm services across Australia offer counselling, financial counselling, helplines, and online services.

Clinical guidelines for non-specialist healthcare providers recommend motivational interviewing, referrals to specialist services, self-exclusion, financial advice, assessing suicidal thoughts, and mental health referrals. In specialist settings, they stress holistic, multidisciplinary care, involving family, setting clear goals, providing evidence-based therapies, addressing co-occurring conditions, and ensuring empathic treatment delivered by trained professionals. Cognitive-behavioural treatment (CBT) and motivational interviewing are effective for treating harmful gambling, although dropout rates are high. Clinical guidelines recommend individual or group CBT and motivational interviewing delivered by trained practitioners. While evidence for other treatments is limited, clinical consensus suggests mindfulness-based therapies, solution-focussed brief therapy, interpersonal psychotherapy, narrative therapy, acceptance and commitment therapy, dialectical behaviour therapy, and family interventions may also be effective. Clinical consensus also suggests effective behaviour change strategies include relapse prevention, goal setting, motivational enhancement, information provision, cognitive restructuring, financial regulation, information gathering, planning social support, problem solving, and decisional balance. These interventions should be delivered face-to-face over at least seven sessions by trained professionals. However, only 1 in 5 people with harmful gambling seek treatment, suggesting the need for self-directed treatments. While these treatments offer small benefits, high-intensity online programs lead to lasting improvements in gambling and mental health. Research on peer support is limited, with mixed findings for Gamblers Anonymous. Online forums, peer support programs, and SMART Recovery are increasingly available but remain untested. Despite this, clinical guidelines recommend offering peer support for those interested. Opioid antagonists and atypical antipsychotics may reduce gambling symptoms in the short-term, but their broader effects are unclear. Clinical guidelines recommend off-label naltrexone use if psychological treatments fail, with specialist oversight and monitoring. Finally, clinical guidelines emphasise relapse as part of recovery, recommending ongoing support, follow-up care, and additional help for high-risk individuals.

3.1. Gambling harm services in Australia

Gambling harm services

Specialist gambling harm services in Australia are funded by state and territory governments, with most offering free therapeutic counselling, financial counselling, helplines, and online services for anyone experiencing harms due to their own or someone else's gambling. Some states and territories have dedicated multicultural and Aboriginal services, criminal justice services, peer support programs, residential treatment, and legal support. Several state and territories also offer apps to support people with harmful gambling. For example, NSW offers many forms of support and assistance:

- GambleAware website: gambleaware.nsw.gov.au
- GambleAware helpline: 1800 858 858
- GambleAware therapeutic and financial counselling: 1800 858 858
- Gambling Help Online chat counselling: gamblinghelponline.org.au
- GambleAware support apps: gambleaware.nsw.gov.au/i-need-support/i-want-to-help-myself/use-apps-to-manage-your-gambling
- Online self-exclusion (Betstop): betstop.gov.au
- Self-exclusion from clubs, pubs, and hotels: mvse.com.au/self-facilitation
- Self-exclusion from casinos:
  - The Star star.com.au/Learn-More-About-Voluntary-Exclusion) and
  - Crown crownsydney.com.au/crown-playsafe/making-a-change
- Self-exclusion from TAB outlets

Treatment goals

Australian gambling harm services adopt a harm minimisation approach, in which both abstinence and non-abstinence treatment goals are acceptable. Non-abstinence goals, such as not gambling on certain gambling activities or reducing the frequency, expenditure, and/or duration of gambling, can reduce barriers to treatment by offering a more realistic and appealing option to some people experiencing harmful gambling. About one-quarter to one-third of people seeking treatment initially select non-abstinence goals but the choice of treatment goal appears fluid, with approximately two-thirds of clients shifting their goal across treatment. Evidence supports the viability non-abstinence as a viable treatment goal.[57]

Therapeutic counselling services

Australian services offer various therapies based on client, clinician, and service preferences. For example, the Sydney University Gambling Treatment and Research Clinic uses a cognitive approach that emphasises uncovering learned beliefs about gambling, identifying maladaptive 'hot thoughts,' and using cognitive challenging techniques to promote healthier thinking patterns. This approach aligns with CBT while highlighting the motivational significance of beliefs and how restructuring them can shift both thinking patterns and gambling behaviour.

3.2. Clinical guidelines for treatment

Guidelines for initial support provided by non-specialist healthcare providers

The draft UK NICE guidelines[34] recommend that non-specialist healthcare providers offer initial support through motivational interviewing and referrals to gambling support resources, healthcare providers, or specialist services. They should also discuss self-exclusion techniques, advise on seeking help with finances, housing, or employment, ask directly about suicidal thoughts, assess social support, and arrange appropriate help. If there is significant risk to the individual or others, an urgent referral to mental health services should be made. As per APS ethical guidelines, the responsibilities of psychologists when working with clients at risk of suicide include maintaining relevant competence, accepting responsibility for the actions they take, disclosing confidential information to reduce the risk of harm to the client and others, weighing up the competing principles of respecting client autonomy and confidentiality against the risk of harm, and considering the extent of consultations with other professionals.[58]

General principles of treatment for specialist providers

These guidelines emphasize key principles for specialist treatment of harmful gambling. Multidisciplinary teams should be used to provide holistic care, and with consent, a trusted person can be involved in joint or individual treatment. Clear goals should be set for gambling and other issues, and evidence-based, cost-effective interventions should be provided. Treatment should be available both online and in-person, with discussions on the pros and cons of each approach. Co-occurring mental health conditions should be addressed, and care

for comorbidities should be coordinated to ensure seamless support. Practitioners delivering treatment must be well-trained, including those providing peer support or group therapy. Finally, fostering engagement through empathy, reducing stigma, and maintaining continuity of care are essential to supporting long-term recovery.

3.3. Psychological interventions

Evidence for psychological treatments

Psychological treatments are effective in the treatment of harmful gambling.[59] CBT significantly reduces gambling behaviour and symptom severity, with approximately two-thirds to three-quarters (65-82%) of people receiving CBT demonstrating greater improvements than controls.[60] Motivational interviewing also improves some gambling outcomes,[61] while other interventions, such as mindfulness-based interventions, are promising but have a smaller evidence base.[62] A dose-response effect is observed, with more sessions leading to better outcomes,[63] although dropout rates are high (39.1%).[64]

Clinical guidelines for psychological treatments

The Australian NHMRC guidelines[35] recommend using individual or group CBT and/or motivational interviewing/Motivational Enhancement Therapies (MET) to reduce gambling behaviour and symptom severity. The more recent draft UK NICE guidelines[34] recommend that specialist providers use motivational interviewing to enhance treatment engagement, offer group CBT to reduce gambling severity and frequency soon after diagnosis, and provide individual CBT if group therapy is unsuitable or not preferred. Group CBT should include 8–10 sessions led by two practitioners, at least one with gambling-specific CBT training, while individual CBT should consist of 6–8 sessions with a trained practitioner, following treatment manuals and incorporating relapse prevention strategies.

Clinical consensus statements for psychological treatments

In the absence of evidence for treatments other than CBT and motivational interviewing, clinical consensus statements from Australian and New Zealand gambling clinicians[65] suggest that effective psychological treatments for harmful gambling may include psychoeducation, mindfulness-based therapies, solution-focussed brief therapy, interpersonal psychotherapy, narrative therapy, acceptance and commitment therapy, dialectical behaviour therapy, and family interventions.

Clinical consensus statements for behaviour change strategies

A subsequent set of clinical consensus statements from the same clinicians[66] and clinical gambling researchers[67] worldwide suggest that effective behaviour change techniques for harmful gambling may include:

- **Relapse prevention:** Relapse prevention involves education about relapse (e.g., on the difference between a lapse and relapse), identifying high-risk situations (such as specific places, people, times of day, thoughts, and emotions), and creating a coping plan for potential setbacks.
- **Goal setting:** Goal setting involves setting a goal to limit, reduce or quit one or more gambling behaviours during treatment or determining accepting activities, frequency, and spending.
- **Motivational enhancement:** Motivational enhancement addresses awareness of the problem, reduces ambivalence and defensiveness, boosts capability and commitment to change, and supports change talk and self-efficacy.

- **Information provision:** Information provision involves education about harmful gambling, its consequences, potential harms, risk factors, as well as the psychology of addiction and how gambling works, including odds, randomness, and chance.
- **Cognitive restructuring:** Cognitive restructuring identifies maladaptive gambling-related thoughts and beliefs (e.g., misunderstanding of randomness, independence of events such as the gamblers fallacy, chance, illusion of control, chasing losses, selective memory biases), challenging them using Socratic questioning and behavioural experiments, and generating more adaptive thoughts or beliefs.
- **Financial regulation:** Financial regulation involves providing guidance on reorganising finances, budgeting, or banking to better manage money.
- **Information gathering:** Information gathering involves assessing the problem through strategic questions, focusing on gambling history, motivations, help-seeking, and related issues, such as comorbid mental health conditions.
- **Planning social support:** Planning social support involves encouraging people to use their support network for emotional or practical support, such as family, friends, or online groups, as well as disclose gambling harms or goals to others and socialise with non-gamblers.
- **Problem solving:** Problem solving involves people identify gambling-related problems, generate and evaluate solutions to these problems, and choosing a solution to implement. It focusses on removing barriers to change and addressing gambling-related problems, like finances, relationships, and employment.
- **Decisional balance:** Decisional balance involves weighing the pros and cons of behaviour change, such as comparing the benefits and costs of gambling versus not gambling. It includes imagining positive outcomes of change or identifying how gambling fits with life goals and values.

Consensus statements for conditions for effective change

Consensus statements from Australian and New Zealand clinicians[66] and clinical gambling researchers worldwide[67] also provide some indication of the conditions under which behaviour change is most likely to occur. They suggest that effective psychological interventions include individual or group therapies that target specific processes of change, especially those using CBT or motivational interviewing approaches, delivered face-to-face by trained professionals. Effective interventions were those that offered more than seven sessions or nine hours of treatment but in which clients completed

more than five sessions. Practitioner supervision, intervention training, the use of a treatment manual, and setting treatment goals of reducing time and/or money spent on gambling were considered effective. Conversely, imposing treatment goals on clients was deemed ineffective.

3.4. Self-directed interventions

Only 1 in 5 people with harmful gambling (20.6%) seek support or treatment.[68] Self-directed treatments can extend the provision of evidence-based support beyond that provided by standard treatments. These interventions demonstrate small improvements in some gambling outcomes at post-treatment[69] including personalised normative feedback interventions, which can reduce short-term gambling symptom severity.[70] However, high-intensity, structured multi-module internet-delivered interventions lead to significant improvements in gambling and psychological outcomes, with effect sizes comparable to face-to-face treatments that are sustained at follow-up.[69]

3.5. Peer support

Despite growing recognition of the benefits of peer support in addiction treatment,[71] research on its effectiveness in gambling recovery is limited. There are mixed findings for Gamblers Anonymous (GA),

with the suggestion that it may be more effective when combined with CBT rather than medication.[72] Virtual gambling communities, typically in the form of online forums, are also increasingly used by people experiencing harmful gambling and offer protection through perceived norms, social influence and community feedback.[73] Increasingly, Australian specialist gambling services offer peer support programs. SMART recovery (Self-Management and Recovery Training), an evidence-based approach grounded in CBT and motivational interviewing, is effective for addiction recovery[74] but remains untested for gambling.[75] Both GA and SMART Recovery groups are expanding online to improve accessibility, particularly for young people and online gamblers.[76] Despite the lack of evidence for harmful gambling, the draft UK NICE guidelines[34] recommend offering it as part of treatment for those who want it.

3.6. Pharmacological interventions

Opioid antagonists (naltrexone, nalmafene) and atypical antipsychotics (olanzapine) may reduce gambling symptom severity in the short-term, but their impacts on other aspects of gambling or psychological functioning are unclear. Evidence for mood stabilisers (including anticonvulsants) is inconclusive and there is limited support for antidepressants.[77] Accordingly, both the Australian NHMRC guidelines[35] and draft UK NICE guidelines[34] recommend off-label use of naltrexone, particularly if psychological treatments are ineffective or relapses occur, stressing its prescription by qualified specialists and monitoring for effectiveness, safety, contraindications, and side effects. The NICE guidelines suggest combining naltrexone with psychological treatments, with increasing dosages over time, while the NHMRC guidelines advise against using antidepressants. As the administration of pharmacological interventions falls outside the scope of psychological practice, non-medical practitioners should approach discussions about medications with care. It is advisable to seek input from a qualified medical professional or encourage clients to consult their prescribing healthcare provider for guidance on medication-related matters.

3.7. Relapse and ongoing support

As indicated earlier, gambling relapse rates are high, with the most frequent high-risk situations including optimism about winning, a need to make money, and unstructured time or boredom, giving in to urges, dealing with negative situations, socialising and fitting in, or seeking excitement or enjoyment.[78]

Accordingly, the draft UK NICE guidelines for harmful gambling[34] recommend that treatment providers recognise relapse as distressing and a potential suicide or self-harm risk. Providers should discuss relapse as a possible part of recovery, emphasising that it is not a failure but may result from individual or environmental factors and that understanding triggers and applying treatment strategies can help reduce relapse risk. Ongoing support, follow-up, and rapid re-access should be tailored to individual needs, with additional support offered to those at higher risk of relapse or who have not met treatment goals. Further assistance, such as extra sessions, peer support, or help with legacy harms, should also be considered.

Section 4: Vulnerable groups

Vulnerable groups include those with psychiatric disorders, young people, dopamine agonist users, those with neurodevelopmental disorders (e.g., ADHD, Autism, and intellectual disability), and those from culturally and linguistically diverse communities.

Culturally responsive frameworks guide culturally appropriate assessment and treatment. Various gambling harm reduction strategies are available in Australia, including Screening, Brief Intervention, and Referral to Treatment, youth prevention programs, pre-commitment limits, self-exclusion, and blocking software.

4.1. Vulnerable subgroups

People with comorbid psychiatric disorders

Harmful gambling frequently co-occurs with psychiatric disorders, most commonly mood, anxiety, and alcohol use disorders, as well as personality disorders, particularly Cluster B disorders (narcissistic, antisocial, borderline) (see Section 1.5 for psychiatric comorbidities and associated risks). Harmful gambling is therefore highly prevalent among people attending mental health and alcohol and substance use services.[79] Most disorders precede harmful gambling, but harmful gambling can also precede some psychiatric disorders in some people. Negative mood states and alcohol or substance use can be high-risk situations for gambling and some people experience negative moods and drink or take drugs after they gamble, thereby creating a cycle for some people. There is relatively limited investigation of psychological treatments designed for people with psychiatric comorbidities, with those available demonstrating limited effectiveness.[80] In the absence of evidence, Australian and New Zealand clinicians[65] agree that psychological interventions are more

effective than no intervention for people with co-occurring issues, although there is no consensus on whether sequenced or simultaneous treatments are more effective.

Young people

One-third (29.8%) of adolescents in NSW[24] have gambled in the past year and 43.4% have gambled at some point in their lives. Popular forms of gambling include private games, lotteries, instant scratch tickets, bingo and keno, with 24.9% gambling online in the past year. Overall, 3.8% gamble more than weekly, with 1.5% reporting problem gambling and 2.2% reporting at-risk gambling. Young adults aged 18-24 years are also a vulnerable subgroup. For example, in NSW, 48.0% have gambled in the past year, with young men (57.2%) more likely to gamble than young women (38.8%). Similar trends are observed for online gambling (24.5%), with young men (32.9%) more likely to gamble online than young women (16.1%). Popular forms of gambling include poker machines (24.7%), lotteries (16.8%), sports betting (13.2%), race betting (10.5%). Risk is highest for this group (6.6%), with young men (9.4%) more likely to report moderate-risk or problem gambling than young women (3.6%). In addition to gender, risk factors include early gambling, exposure to gambling ads, betting on multiple activities, family issues, having gambling peers or family members, difficulty coping, anxiety or depression, impulsivity, risk-taking, attention and/or hyperactivity issues, substance use, behavioural problems, and poor school performance.[81] In addition, 13.7% of Australian children are exposed to harmful gambling by a parent each year,[82] leading to financial harm, abuse, neglect, relational problems and psychological issues[83]. These harms can persist into adulthood, with affected children more likely to experience depression, anxiety, PTSD, intimate partner violence and harmful gambling themselves. As per the APS ethical guidelines for working with young people,[84] it is important for psychologists to consider the organisation's policies and consider the young person's best interests, their capacity to provide informed consent, whether parents are clients, whether the young person is to be seen on their own, confidentiality limits, and information disclosure. Psychologists should review their procedures for working with young people, establish clear consent at the start and if changes occur, and regularly consult with colleagues on these matters. See Section 4.2 for information on youth prevention programs.

People using dopamine agonist medications

Dopamine replacement therapy for Parkinson's disease has been linked to harmful gambling.[85] However, the development of harmful gambling

development is complex and may be attributed to individual vulnerability and environmental factors, as well as the effects of these dopaminergic drugs. As medication management is outside the scope of psychological practice, non-medical practitioners should seek input from a qualified medical professional or refer clients to their prescribing healthcare provider for guidance.

Neurodevelopmental disorders

Other vulnerable groups include those with neurodevelopmental disorders, including Attention Deficit Hyperactivity Disorder (ADHD), Autism, and intellectual disability.[86] Most literature focusses on ADHD, with varying rates of comorbidity, with rates of harmful gambling in ADHD populations ranging from 7.9% to 19.0% and rates of ADHD in harmful gambling samples ranging from 4.2% to 50%. Limited research examining Autism concluded that the association between autistic traits and harmful gambling symptoms remain significant even after adjusting for ADHD. Finally, a small evidence base relating to intellectual disability found that people with harmful gambling had high rates of intellectual disability diagnosis (22.3%) and cognitive impairment (42.5%). There may therefore be concerns around the mental capacity of this subgroup to understand gambling-related risks and harms and manage their finances, thereby raising the possibility of financial guardianship. The APS ethical guidelines

for psychological practice with clients with an intellectual disability[87] highlights the importance of psychologists respecting the rights and dignity of individuals with intellectual disabilities, ensuring they can participate in decisions about their care. Psychologists should adapt their communication and consent processes to meet the needs of these clients, consult legal guardians when necessary, and comply with relevant disability legislation. Common features of neurodevelopmental disorders and harmful gambling, such as impulsivity, emotion dysregulation, compulsivity, and cognitive distortions, are appropriate therapeutic targets for this vulnerable subgroup.

People from diverse communities

There is limited research, with mixed findings, relating to gambling among culturally and linguistically diverse communities in Australia, partly due to differences and nuances in culture and environments. This is consistent with mental health more broadly, in which different cultures conceptualise mental distress in diverse ways, and these explanations influence help-seeking behaviours and treatment adherence. For example, psychological distress may be described as "tension" or "pressure in the head" rather than depression in South Asian communities. Reviews summarising gambling in culturally and linguistically diverse communities provide several key insights.[88] First, many findings suggest that people from these communities are less likely to gamble, but those who do gamble are more likely to develop harmful gambling. Second, there is an apparent contradiction of attitudes towards gambling as both taboo and normal. Some cultures view gambling as a socially normed activity (e.g., in some Middle Eastern communities), while some hold beliefs about luck and chance (e.g., in some Asian communities). Some may view gambling as a normal part of Australian culture, with increased exposure to advertising, easier access, and welcoming environments heightening their vulnerability. Third, migrants may be particularly susceptible due to isolation, migration stress, trauma, boredom, disadvantage, or a desire to make the most of their new life.[88] International students are also more vulnerable. Finally, other factors include stigma and shame associated with seeking help and limited access to culturally appropriate support (e.g., using bilingual counsellors).

Aboriginal and Torres Strait Islander communities specifically experience higher rates of harmful gambling,[89] due to factors like historical trauma, lower socio-economic status, and mental health and addiction issues, as well as cultural beliefs, historical gambling norms, and reciprocal obligation values. These populations have lower uptake of gambling help services, which may be linked to a lack of culturally appropriate support (e.g., using community-based outreach). Few interventions have been specifically designed for these populations, but those available focus on prevention, harm reduction, or healing facilitation using an emancipatory approach, community engagement, co-design, local involvement, cultural integration, community capacity building, and service organisation and community partnerships.

Culturally responsive frameworks from Australia[90] suggest that culture itself and being from a culturally and linguistically diverse background is not the reason why some groups may be more vulnerable to gambling-related harm. They suggest that contributing factors can be summarised as broadly relating to:

- **Socio-economic challenges:** Socio-economic challenges such as unemployment and low income, often faced by migrants and refugees, can increase vulnerability to harmful gambling.
- **Migration experience:** Being from a non-Caucasian background can increase gambling harm risks due to systemic racism and socioeconomic disadvantages, not inherent cultural factors.
- **Migration and acculturation:** Immigrants and those with migration backgrounds are more likely to experience harmful gambling, especially if they face cultural adjustment, stress, and lack of social outlets.
- **Community resources and infrastructure:** Access to community resources and services enhances resilience and reduces vulnerability, but limited resources for culturally diverse communities hinder effective support for harm minimisation.
- **Culturally influenced help-seeking behaviours:** Help-seeking for gambling harm is generally low with culturally and linguistically diverse communities facing additional barriers such as shame, stigma, and limited service support.

In these frameworks, cultural competency and related terms emphasise the importance of service providers understanding and respecting diverse cultural backgrounds, with a more contemporary approach, cultural responsiveness, focusing on mutual respect and empowering individuals while improving access and outcomes for marginalised groups. Becoming culturally responsive involves ongoing reflection, developing skills such as understanding vulnerabilities, accepting cultural differences, avoiding stereotyping, recognising personal biases, and effectively working with diverse groups in a supportive, non-discriminatory way. Creating a cultural profile for all groups in Australia is impractical,

but a culturally responsive approach can be grounded in key principles, such as cultural knowledge, practice, and change to improve health interventions and long-term outcomes.

Gambling-related harm should be addressed holistically, considering socioeconomic and environmental factors, with both culturally specific and appropriate mainstream support services to effectively assist culturally and linguistically diverse communities. Effective ways of working with people from culturally and linguistically diverse communities include:

- ***Effective community engagement*** is important for successful harm minimisation programs, with workers connecting directly to the community to raise awareness and promote social cohesion.
- ***Accessibility*** of gambling harm initiatives, including bilingual support and convenient locations/times, is key to success for culturally and linguistically diverse communities.
- ***Tailored and bespoke initiatives*** are essential for effective support, though challenging to provide for culturally and linguistically diverse individuals.
- ***Evidence-based practice*** with clear benchmarks and better-resourced culturally specific services, alongside culturally responsive training for mainstream services, are essential for effective gambling harm minimisation.

- ***Specialist subject matter knowledge***, alongside cultural responsiveness, is important for effective outcomes and informed contributions to policy, with strategic training and staff placement addressing this gap.
- ***Community education***, with the support of leaders and elders, is an effective method for gambling harm minimisation, addressing unfamiliarity with Western interventions and available services.
- ***Peer-led initiatives***, or those informed by lived experience, are highly valued for their engaging, relatable narrative that fosters hope and optimism.

Screening tools may not fully capture mental health symptoms as experienced or expressed in diverse cultural groups. Culturally adapted screening tools modify language, symptom descriptions, or diagnostic thresholds to better reflect the lived experience of different communities. There are many culturally adapted and translated instruments measuring gambling symptom severity and other gambling-related constructs.

Australian and New Zealand clinicians identified several main considerations or adaptations to using behaviour change techniques with people from culturally diverse, linguistically diverse, or Indigenous populations.[66] While they agreed on the need for adaptation, opinions differed on whether to prioritise cultural or individual tailoring, with some emphasising the therapeutic relationship. Providing materials in the client's first language and ensuring culturally appropriate explanations were seen as essential. Family and community involvement can be beneficial but may be hindered by stigma, shame, or social acceptance of gambling. Techniques like mindfulness and social skills training may be effective for certain cultures, but addressing barriers such as trauma, social support, and financial literacy should be addressed first.

4.2. Prevention and harm reduction strategies

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is an evidence-based approach used in various healthcare and support settings to identify and intervene with people at risk of harmful gambling. While evidence for its effectiveness and cost-effectiveness is limited, it demonstrates promising results and is feasible and acceptable in community and healthcare settings, including general practice, mental health services, consumer credit, and social work settings.[91] Despite lacking evidence of effectiveness, these approaches are being used in practice.

Youth prevention interventions

Prevention and treatment programs for adolescent and young adult gambling mainly target educational settings.[92,93] Secondary school programs mainly using gambling education programs designed to raise awareness of signs, symptoms and consequences and correct misperceptions and beliefs, while university student programs target high-risk individuals. These programs demonstrate promising outcomes in terms of reduced gambling frequency, gambling symptom severity, and cognitions. Recommendations include teaching mathematical principles, staggering content delivery, using multi-media platforms, and connecting new knowledge to familiar experiences.

Pre-commitment/limit setting

Pre-commitment systems help to reduce gambling harm by allowing gamblers to set limits on money and time, either voluntarily or mandatorily. While voluntary systems in Australia have improved awareness, limit adherence, turnover, and expenditure, their effectiveness is limited by low uptake and participation,[94] whereas mandatory systems in other parts of world, which have universal limits and binding restrictions, are more effective.[95] Various inquiries and reviews in Australia have recommended implementing mandatory systems with single cards, verifiable identities, binding limits, and cooling-off periods.

Self-exclusion

Self-exclusion programs allow individuals to voluntarily block themselves from land-based venues or online gambling operators for a set period.

- **Land-based gambling venue exclusion:** These programs involve banning people from multiple venues, submission of personal details, penalties for breaches, forfeiture of winnings, revocation conditions, and referrals to treatment. While participation is low,[96] those who engage report decreased gambling, reduced spending, and improved well-being.[97] However, challenges such as a lack of a national register, stigma, undetected breaches, inadequate identity verification, complex procedures, and rigid exclusion periods undermine effectiveness. Family member[98] or operator-enforced99 third-party exclusions are less common but may also offer some benefit.
- **Online self-exclusion:** Mandatory identification for online gambling enables self-exclusion. Australia's "BetStop" offers a free national self-exclusion register, allowing exclusions from all licensed interactive wagering services for a minimum of 3 months. Wagering providers are required to close all accounts, block new account registrations, and prohibit marketing communications. Online self-exclusion can reduce gambling behaviours, cognitions and urges[100] but breaches occur, often on unlicensed sites. In addition to exclusion, operators can offer temporary exclusions, like panic buttons or cooling-off periods.

Blocking software

Users can install various blocking software to prevent gambling harm. These tools include general blocking software, which allow people to set authorisations or parental controls to prevent or monitor access to a range of websites or apps; gambling blocking software, which blocks digital gambling services and limits advertising from online gambling providers; ad blockers, which filter or block ads on web browsers; and payment blockers, which prevention transactions on gambling sites.

Section 5: Affected family members and friends

In Australia, one in 20 adults have been harmed by another person's gambling.

Affected family members and friends are often younger, employed, and living with children. They experience higher gambling problems themselves, as well as higher mental health issues and lower quality of life. Family members and friends experience harm across various domains, most commonly emotional and relationship harm, with partners and children most affected. Harm, which also varies based on emotional closeness, financial connectedness, and gambling severity, can last into the future. Few brief, validated instruments are available to assess family members and friends. In Australia, a single item measure is most often used for screening, while the Short Questionnaire for Family Members Affected by Addiction assesses stressors, harms, coping, and social support/help-seeking. Screening can also identify urgent issues needing treatment or referral. Despite the harm they experience, few affected family members or friends seek help. Low-intensity online treatments show promise in reaching those who might not seek help otherwise. Other family member and friend treatments are well-received but have somewhat limited efficacy, while couple treatments appear promising but need further study.

5.1. Prevalence and profiles

Gambling harm extends beyond the person who gambling, affecting family members and friends, who are sometimes referred to as *affected others* or *concerned significant others*. The Stress–Strain-Coping-Support (SSCS) model,[101] which is widely used to guide the assessment and treatment of family members and friends, suggests that chronic gambling-related stress leads to strain on the health and wellbeing of family members, with social support and coping influencing the extent of this strain.

In Australia, one person's gambling problem negatively impacts, on average, at least six others, with moderate-risk and low-risk gambling affecting on three others and one other, respectively.[102] National estimates indicate that one in 20 adults (5.1-6.0%) have been harmed by another person's gambling.[103] Family members and friends experiencing gambling harm in Australia e.g.[103] tend to be younger, Australian-born, employed, retired, living with children, speaking a language other than English, unmarried, in defacto relationships, and divorced or separated. They have higher gambling participation, problems, and harms resulting from their own gambling. They also have higher depression, anxiety, panic, PTSD, binge drinking, tobacco use, and drug use and lower quality of life.

5.2. Gambling-related harm

Family members and friends can experience gambling harms across emotional, financial, relationship, health, work or study, cultural, and criminal domains,[104] with emotional harms (89.3%) and relationship harms (76.2%) being the most common in Australia. These harms can extend in the future, with over half of family members and friends reporting harms in the past year (57.5%) also reporting a legacy harm. The extent of harm varies by factors such as emotional closeness, financial connectedness, shared day-to-day responsibilities, shared time together, and gambling severity. Harm extends to immediate and extended family, friends, and colleagues, but is generally highest for current or former partners and children. There are often differing perceptions of harm between people who gamble and their family members and friends, suggesting varied experiences.

5.3. Assessment

Few brief fit-for-purpose instruments with good evaluation data are available to assess impacted family members and friends, with the available tools screening for "affected other status" and measuring gambling-related stressors, gambling harms, coping, and social support or help-seeking.[105]

In Australia, a single item has most often been used to identify impacted family members and friends: *"In the past 12 months, have you been personally affected by another person's gambling?"*, with a binary (yes or no) response option. This can be followed up with an item asking their relationship to the person who has affected them (or affected them the most), such as spouse/partner, parent/stepparent, child/stepchild, other person (in your household), other family member (not in your household), ex-partner, work colleague, friend, neighbour, and other person. This allows for the identification of "affected family members", "affected non-family members", and "affected close friends".

Of the remaining available measures, the 33-item Short Questionnaire for Family Members Affected by Addiction (SQFM-AA)[106] offers the briefest measure with broad coverage of key SSCS elements: gambling-related stressors, gambling harms, coping, and social support. A Total Family Burden (TFB) score can be calculated and is suitable for treatment outcome monitoring. The 10-item Gambling Harm Scale-10-Affected Others (GHS-10-AO), which was recently developed in Australia, also offers a brief and validated measure of gambling harm.[107]

Because these tools are limited, they can be supplemented or replaced with generic measures, including those measuring depression, anxiety, stress, functional impairment, and wellbeing or quality of life. Screening can also be used to assess risk for urgent issues that may require immediate treatment or referral, such as suicidal ideation, family violence, hazardous alcohol use, other drug use, depression, and anxiety. Given impacted family members and friends have high rates of problems and harm resulting from their own gambling, they should be screened for harmful gambling using the 3-item NODS-CLiP,[38] 4-item NODS-PERC,[39] 2-item Lie/Bet Questionnaire[40] or One-Item Screen.[41]

5.4. Treatment

In Australia, 2.3% of family members or friends affected by gambling have ever sought help for their own gambling, with no gender differences, while 14.2% have ever sought help for someone else's gambling, with women more likely to do so.[103] Psychological treatments focus on equipping them to support the person who gambles (gambler-focused treatments) and/or helping them manage the impacts of gambling on themselves (family-focused treatments).[105] Accordingly, the draft UK NICE guidelines[34] recommend that providers of treatment services offer support to affected family members and friends both by themselves or together, including techniques to manage their own distress and/or to support the recovery of the person who gambles.

Affected other treatments

Limited research has evaluated treatments specifically developed for family members and friends experiencing gambling harm, including Community Reinforcement and Family Training (CRAFT), the 5-Step method, coping skills training (CST), and internet-delivered interventions. See Dowling et al. (2025) for more information on each of these interventions.[105]

- **CRAFT:** CRAFT, a CBT approach for families of treatment-resistant drinkers, combines gambler- and family-focused strategies to improve personal and family functioning, engage the person who gambles in treatment, and reduce gambling. CRAFT improves gambling behaviour, personal and relationship functioning, negative gambling consequences, and treatment entry, as well as greater satisfaction and acceptability than control groups. Face-to-face delivery demonstrates higher acceptability but similar outcomes to workbook delivery.

- **5-Step Method:** The 5-Step Method workbook, adapted from substance use, supports family members address key components of the SSCS model: gambling-related stress and strains, knowledge and confidence, coping strategies, social support, and additional needs and resources. This approach has demonstrated improvements in some measures of impact, coping, strain, and social support.
- **Coping Skills Training:** CST is a family-focused intervention that aims to improve coping skills and distress. It includes psychoeducation, stress management, coping models, the relationship between thoughts, feelings, and behaviours, problem-solving, and communication skills, followed by skills reinforcement, homework review, skills coaching through modelling and role-playing. CST has demonstrated greater improvements in cognitive and behavioural coping skills, tolerant coping, depression, and anxiety than a control group.
- **Internet-delivered interventions:** Internet-based interventions include a 9-module CBT program with minimal therapist support inspired by CRAFT including psychoeducation, functional analysis, gambling-free activities, rewards, behavioural activation, financial protection, enabling behaviours, communication training, MI, problem solving, and treatment entry. It demonstrated improvements in emotional consequences, relationship satisfaction, anxiety, and depression. Another program, a free e-mental health resource, included psychoeducation, stress and coping, responsibility and accountability, communication, and social support. On average, 16 new users registered each month, making 6,357 visits with an average duration of 7 minutes and an average completion time of 31 days.

Couple and family treatments

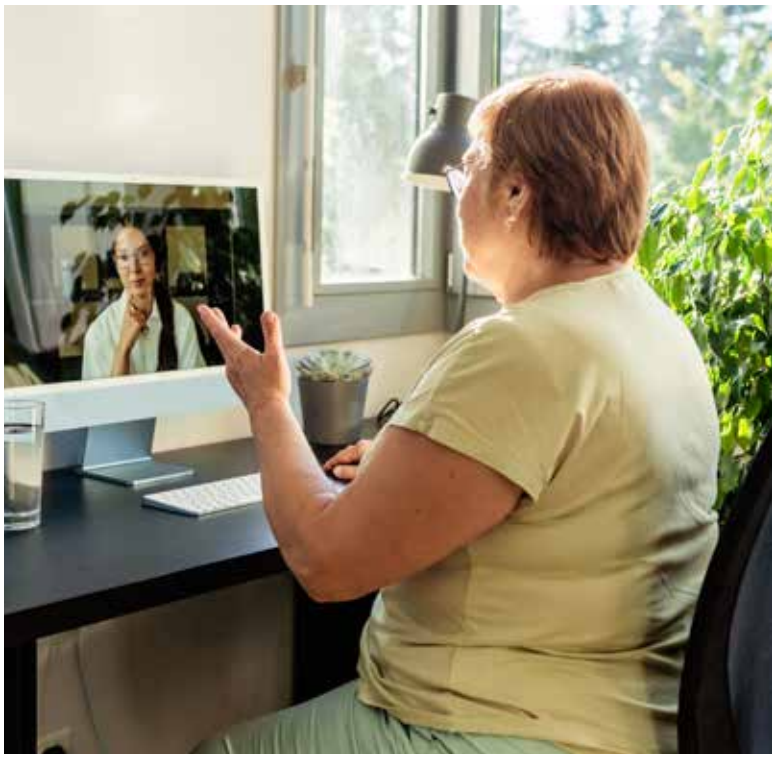
Limited research has evaluated couple and family treatments, including congruence couple therapy (CCT), behavioural couples therapy (BCT), and integrative couple treatment for pathological gambling (ICT-PG). See Dowling et al. (2025) for more information on each of these interventions.[105]

- **Congruence Couple Therapy:** CCT is a couple therapy aiming to align four key dimensions (interpersonal, intrapsychic, spiritual-universal, intergenerational) to improve awareness, choice, flexibility, self-esteem, communication, and transcendence of adverse intergenerational patterns. CCT has demonstrated improvements in gambling severity, relationship quality, mental distress, and family functioning, with high treatment satisfaction.

- **Behavioural Couples Therapy:** Internet-delivered BCT, designed to improve relationship functioning to support abstinence, adds CBT for partners to CBT for gamblers and includes psychoeducation, behavioural analysis, economic recovery planning, motivation enhancement, behavioural activation, cognitive restructuring, values and goals, communication skills training, and relapse prevention. Gamblers have improved on all outcomes in both gambler-CBT and BCT, while partners in BCT have reported greater reductions in anxiety, depression, and gambling consequences compared to gambler-CBT.
- **Integrative Couple Treatment: I**CT-PG, delivered in 8-12 sessions, aims to reduce gambling and improve distress, wellbeing, relationship satisfaction, and mutual support. Compared to treatment-as-usual, couples in ICT-PG have reported higher satisfaction, gamblers in ICT-PG have demonstrated greater improvements in gambling severity, impaired control, erroneous cognitions, dyadic adjustment, marital problem solving, communication skills, and depression, and partners in ICT-PG have demonstrated greater improvements in erroneous cognitions, dyadic adjustment, depression and psychological distress.

5.5. Limits to confidentiality

Maintaining confidentiality can be challenging for psychologists when they are aware that client is causing significant harm to another person or may pose a risk of doing so in the future. One difficult circumstance which can arise is when a client discloses financial harm or gambling-related crime, such as theft. Clients who admit to gambling-related theft can present a dilemma for psychologists, who may need to determine whether they have a professional obligation to warn or otherwise safeguard third parties who may or may not be involved in treatment.[108] The APS Code of Ethics provides guidance on when and how confidentiality can be broken in the case of a serious threat to the client or others.[109] The APS ethical guidelines for reporting abuse and neglect and criminal activity also provides guidelines when it comes to past or intended criminal activity.[110]



Before deciding what course of action to take, psychologists should consider their primary role when providing a psychological service to a client. They should consider the seriousness of the offence, the likely impact on the victim(s), the ongoing risk to the victim(s), the client's best interests, the impact on the ongoing psychologist-client relationship, the role of the psychologist-client relationship in managing and monitoring potential risks, the process for reporting and the likely outcomes of reporting; and the advice of experienced colleagues.

For situations in which clients disclose threats to commit a criminal offence, psychologists should consider relevant legislation, required reporting processes, and any workplace policies and procedures that mandate reporting suspected criminal activity. If working within an agency or organisation, they should determine the appropriate person to report to. It is also important to assess the level of risk posed by the intended crime to the client or others, the potential harm if not report is made, and how an intended victim would be warned. Consulting with a senior colleague or the APS Professional Advisory Service (1800 333 497) is advisable.

References

1. Potenza, M. N. (2006). Should addictive disorders include non-substance-related conditions? *Addiction, 101 Suppl 1, 142-151.* https://doi.org/10.1111/j.1360-0443.2006.01591.x
2. Potenza, M. N., Koran, L. M., & Pallanti, S. (2009). The relationship between impulse-control disorders and obsessive-compulsive disorder: a current understanding and future research directions. *Psychiatry Res, 170(1), 22-31.* https://doi.org/10.1016/j.psychres.2008.06.036
3. American Psychiatric Association. (2022). Diagnostic and statistical manual of mental disorders (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787
4. World Health Organization. (2019). International statistical classification of diseases and related health problems (11th ed.). https://doi.org/https://icd.who.int/
5. Shaffer, H. J., & Korn, D. A. (2002). Gambling and related mental disorders: a public health analysis**.** *Annu Rev Public Health, 23, 171-212.* https://doi.org/10.1146/annurev.publhealth.23.100901.140532
6. Neal, P., Delfabbro, P., & O'Neil, M. (2005). *Problem gambling and harm: Towards a national definition. Gambling Research Australia.* https://www.gamblingresearch.org.au/publications/problem-gambling-and-harm-towards-national-definition
7. Langham, E., Thorne, H., Browne, M., Donaldson, P., Rose, J., & Rockloff, M. (2016). Understanding gambling related harm: A proposed definition, conceptual framework, and taxonomy of harms. *BMC Public Health, 16(1), 80.* https://doi.org/10.1186/s12889-016-2747-0
8. Browne, M., Nancy, G., Vijay, R., & and Rockloff, M. (2017). A population-level metric for gambling-related harm. *International Gambling Studies, 17(2), 163-175.* https://doi.org/10.1080/14459795.2017.1304973
9. Delfabbro, P., & King, D. L. (2020). Don't say the 'P' word: Problem gambling is more than harm. *International Journal of Mental Health and Addiction, 18(3), 835-843.* https://doi.org/10.1007/s11469-020-00274-4
10. Victorian Responsible Gambling Foundation. (2024). *Reducing stigma: A guide for talking about gambling harm.* https://responsiblegambling.vic.gov.au/documents/1266/FINAL_-_Gambling_harm_language_guide_-_March_2024.pdf
11. Abbott, M., Binde, P., Clark, L., Hodgins, D., Johnson, M., Manitowabi, D., Quilty, L., Spångberg, J., Volberg, R., Walker, D., & Williams, R. (2018). *Conceptual framework of harmful gambling: An international collaboration. Gambling Research Exchange Ontario.* https://doi.org/10.33684/CFHG3.en
12. el-Guebaly, N., Casey, D. M., Hodgins, D. C., Smith, G. J., Williams, R. J., Schopflocher, D. P., & Wood, R. T. (2008). Designing a longitudinal cohort study of gambling in Alberta: Rationale, methods, and challenges. *Journal of Gambling Studies, 24(4), 479-504.* https://doi.org/10.1007/s10899-008-9108-6
13. Shaffer, H. J., LaPlante, D. A., LaBrie, R. A., Kidman, R. C., Donato, A. N., & Stanton, M. V. (2004). Toward a syndrome model of addiction: Multiple expressions, common etiology. *Harvard Review of Psychiatry, 12(6), 367-374.* https://doi.org/10.1080/10673220490905705
14. Blaszczynski, A., & Nower, L. (2002). A pathways model of problem and pathological gambling. *Addiction, 97(5), 487-499.* https://doi.org/10.1046/j.1360-0443.2002.00015.x
15. Kurilla, A. (2021). Is Subtyping of gamblers based on the pathways model of problem and disordered gambling valid? A systematic review. *J Gambl Stud, 37(3), 983-1006.* https://doi.org/10.1007/s10899-020-09995-6
16. Nower, L., Blaszczynski, A., & Anthony, W. L. (2022). Clarifying gambling subtypes: The revised pathways model of problem gambling. *Addiction, 117(7), 2000-2008.* https://doi.org/10.1111/add.15745
17. Dowling, N. A., Merkouris, S. S., Greenwood, C. J., Oldenhof, E., Toumbourou, J. W., & Youssef, G. J. (2017). Early risk and protective factors for problem gambling: A systematic review and meta-analysis of longitudinal studies. *Clin Psychol Rev, 51, 109-124.* https://doi.org/10.1016/j.cpr.2016.10.008

18. Williams, R. J., & Williams, H. A. (2025). The trajectory, chronicity, and etiology of problem gambling: A synthesis of longitudinal research. *Current Addiction Reports, 12(1), 5.* https://doi.org/10.1007/s40429-025-00622-1

19. The Australian Psychological Society. (2022). *Inquiry into online gambling and its impact on those experiencing gambling harm.* https://psychology.org.au/psychology/advocacy/submissions/professional-practice/2022/inquiry-into-online-gambling-and-its-impact-on-tho

20. Dowling, N. A., Youssef, G. J., Jackson, A. C., Pennay, D. W., Francis, K. L., Pennay, A., & Lubman, D. I. (2016). National estimates of Australian gambling prevalence: findings from a dual-frame omnibus survey. *Addiction, 111(3), 420-435.* https://doi.org/https://doi.org/10.1111/add.13176

21. Gainsbury, S. M., Russell, A., Hing, N., Wood, R., Lubman, D. I., & Blaszczynski, A. (2014). The prevalence and determinants of problem gambling in Australia: Assessing the impact of interactive gambling and new technologies. *Psychology of Addictive Behaviors, 28(3), 769-779.* https://doi.org/10.1037/a0036207

22. Hing, N., Russell, A. M. T., Browne, M., Rockloff, M., Greer, N., Rawat, V., Stevens,, & M., D., N., Merkouris, S., King, D., Breen, H., Salonen, A., & Woo, L. (2021). *The second national study of interactive gambling in Australia (2019-20). Gambling Research Australia.*

23. Browne, M., Russell, A. M. T., Dellosa, G., Rockloff, M. & Hing, N. (2024). *NSW Gambling Survey 2024. NSW Responsible Gambling Fund.* https://www.gambleaware.nsw.gov.au/resources-and-education/check-out-our-research/published-research/nsw-gambling-survey-2024

24. Hing, N., Russell, A., King, D., Rockloff, M., Browne, M., Greer, N., Newall, P., Sproston, K., Chen, L., & Coughlin, S. (2020). *NSW Youth Gambling Study 2020. NSW Responsible Gambling Fund.* https://www.gambleaware.nsw.gov.au/resources-and-education/check-out-our-research/published-research/nsw-youth-gambling-study-2020

25. Petro, M. (2013). Evaluating, treating and preventing deviant effects of gambling through schools and school curriculums. *Mediterranean Journal of Social Sciences, 4.* https://doi.org/10.5901/mjss.2013.v4n2p381

26. Jiménez-Murcia, S., Álvarez-Moya, E. M., Stinchfield, R., Fernández-Aranda, F., Granero, R., Aymamí, N., Gómez-Peña, M., Jaurrieta, N., Bove, F., & Menchón, J. M. (2010). Age of onset in pathological gambling: Clinical, therapeutic and personality correlates. *Journal of Gambling Studies, 26(2), 235-248.* https://doi.org/10.1007/s10899-009-9175-3

27. Dowling, N. A., Cowlishaw, S., Jackson, A. C., Merkouris, S. S., Francis, K. L., & Christensen, D. R. (2015). Prevalence of psychiatric co-morbidity in treatment-seeking problem gamblers: A systematic review and meta-analysis. *Aust N Z J Psychiatry, 49(6), 519-539.* https://doi.org/10.1177/0004867415575774

28. Dowling, N. A., Cowlishaw, S., Jackson, A. C., Merkouris, S. S., Francis, K. L., & Christensen, D. R. (2015). The prevalence of comorbid personality disorders in treatment-seeking problem gamblers: A systematic review and meta-analysis. *J Pers Disord, 29(6), 735-754.* https://doi.org/10.1521/pedi_2014_28_168

29. Dowling, N., Suomi, A., Jackson, A., Lavis, T., Patford, J., Cockman, S., Thomas, S., Bellringer, M., Koziol-Mclain, J., Battersby, M., Harvey, P., & Abbott, M. (2016). Problem gambling and intimate partner violence: A systematic review and meta-analysis. *Trauma Violence Abuse, 17(1), 43-61.* https://doi.org/10.1177/1524838014561269

30. Dowling, N. A., Jackson, A. C., Suomi, A., Lavis, T., Thomas, S. A., Patford, J., Harvey, P., Battersby, M., Koziol-McLain, J., Abbott, M., & Bellringer, M. E. (2014). Problem gambling and family violence: prevalence and patterns in treatment-seekers. *Addict Behav, 39(12), 1713-1717.* https://doi.org/10.1016/j.addbeh.2014.07.006

31. Hing, N., Nuske, E., Breen, H., O'Mullan, C., Mainey, L., & Thomas, A. (2022). Problem gambling and economic abuse against women: An adaptive grounded theory analysis. *Addiction Research & Theory, 30(3), 169-179.* https://doi.org/10.1080/16066359.2021.1962847

32. Hing, N., O'Mullan, C., Mainey, L., Greer, N., & Breen, H. (2022). An integrative review of research on gambling and domestic and family violence: Fresh perspectives to guide future research. *Front Psychol, 13, 987379.* https://doi.org/10.3389/fpsyg.2022.987379

33. Kristensen, J. H., Pallesen, S., Bauer, J., Leino, T., Griffiths, M. D., & Erevik, E. K. (2024). Suicidality among individuals with gambling problems: A meta-analytic literature review. *Psychological Bulletin, 150(1), 82-106*. https://doi.org/10.1037/bul0000411

34. National Institute for Health and Care Excellence. (2023). *Harmful gambling: Identification, assessment and management: Draft for consultation*. https://www.nice.org.uk/guidance/ng248/documents/draft-guideline

35. Problem Gambling Reseach and Treatment Centre. (2011). *Guideline for screening, assessment and treatment in problem gambling. Monash University*.

36. Aslan, I. H., Dowling, N. A., Ioannidis, K., Grant, J. E., Chamberlain, S. R. (2025). *Assessing gambling disorder: A narrative review. [Manuscript submitted for publication]*.

37. Dowling, N. A., Merkouris, S. S., Dias, S., Rodda, S. N., Manning, V., Youssef, G. J., Lubman, D. I., & Volberg, R. A. (2019). The diagnostic accuracy of brief screening instruments for problem gambling: A systematic review and meta-analysis. *Clin Psychol Rev, 74, 101784*. https://doi.org/10.1016/j.cpr.2019.101784

38. Toce-Gerstein, M., Gerstein, D. R., & Volberg, R. A. (2009). The NODS-CLiP: A rapid screen for adult pathological and problem gambling. *J Gambl Stud, 25(4), 541-555*. https://doi.org/10.1007/s10899-009-9135-y

39. Volberg, R. A., Munck, I. M., & Petry, N. M. (2011). A quick and simple screening method for pathological and problem gamblers in addiction programs and practices. *Am J Addict, 20(3), 220-227*. https://doi.org/10.1111/j.1521-0391.2011.00118.x

40. Johnson, E. E., Hamer, R., Nora, R. M., Tan, B., Eisenstein, N., & Engelhart, C. (1997). The Lie/Bet Questionnaire for screening pathological gamblers. *Psychol Rep, 80(1), 83-88*. https://doi.org/10.2466/pr0.1997.80.1.83

41. Thomas, S., Jackson, A., Browning, C., & Piterman, L. (2010). *A one item screening tool for problem gambling for use in primary care settings. Unpublished Manuscript*

42. Ferris, J., & Wynne, H. (2001). *The Canadian Problem Gambling Index*. https://www.jogoremoto.pt/docs/extra/TECb6h.pdf

43. Merkouris, S. S., Greenwood, C., Manning, V., Oakes, J., Rodda, S., Lubman, D., & Dowling, N. A. (2020). Enhancing the utility of the problem gambling severity index in clinical settings: Identifying refined categories within the problem gambling category. *Addict Behav, 103, 106257*. https://doi.org/10.1016/j.addbeh.2019.106257

44. Molander, O., Volberg, R., Månsson, V., Sundqvist, K., Wennberg, P., & Berman, A. H. (2021). Development of the gambling disorder Identification Test: Results from an international Delphi and consensus process. *Int J Methods Psychiatr Res, 30(2), e1865*. https://doi.org/10.1002/mpr.1865

45. Gerstein, D., Murphy, S., Toce, M., Hoffman, J., Palmer, A., Johnson, R., Larison, C., Chuchro, L., Buie, T., Engelman, L., Chuchro, L., Hill, M. A., Volberg, R., Harwood, H., Tucker, A., Christiansen, E., Cummings, W., & Sinclair, S. (1999). *Gambling impact and behavior study: Report to the National Gambling Impact Study Commission*. https://www.norc.org/content/dam/norc-org/pdfs/GIBSFinalReportApril1999.pdf

46. Brazeau, B. W., & Hodgins, D. C. (2022). Psychometric evaluation of the NORC diagnostic screen for gambling problems (NODS) for the assessment of DSM-5 gambling disorder. *Addict Behav, 130, 107310*. https://doi.org/10.1016/j.addbeh.2022.107310

47. Blaszczynski, A., Robert, L., & and Moodie, C. (2008). The Sydney Laval Universities Gambling Screen: Preliminary data. *Addiction Research & Theory, 16(4), 401-411*. https://doi.org/10.1080/16066350701699031

48. Walker, M., Toneatto, T., Potenza, M. N., Petry, N., Ladouceur, R., Hodgins, D. C., el-Guebaly, N., Echeburua, E., & Blaszczynski, A. (2006). A framework for reporting outcomes in problem gambling treatment research: The Banff, Alberta Consensus. *Addiction, 101(4), 504-511*. https://doi.org/10.1111/j.1360-0443.2005.01341.x

49. Weinstock, J., Whelan, J. P., & Meyers, A. W. (2004). Behavioral assessment of gambling: An application of the timeline followback method. *Psychol Assess, 16(1), 72-80*. https://doi.org/10.1037/1040-3590.16.1.72

50. Paul, M. L., Meinerding, M., Weinstock, J., Ginley, M. K., Whelan, J. P., & Pfund, R. A. (2024). Minimizing measurement error in treatment outcome estimates: A meta-analysis comparing estimates between the gambling timeline followback and other self-report assessments of gambling behavior. *Psychol Addict Behav, 38(6), 704-715.* https://doi.org/10.1037/adb0001024

51. Kim, S. W., Grant, J. E., Potenza, M. N., Blanco, C., & Hollander, E. (2009). The Gambling Symptom Assessment Scale (G-SAS): A reliability and validity study. *Psychiatry Res, 166(1), 76-84.* https://doi.org/10.1016/j.psychres.2007.11.008

52. Pickering, D., Blaszczynski, A., & Gainsbury, S. M. (2021). Development and psychometric evaluation of the Recovery Index for gambling disorder (RIGD). *Psychol Addict Behav, 35(4), 472-485.* https://doi.org/10.1037/adb0000676

53. Browne, M., Goodwin, B. C., & Rockloff, M. J. (2018). Validation of the Short Gambling Harm Screen (SGHS): A tool for assessment of harms from gambling. *J Gambl Stud, 34(2), 499-512.* https://doi.org/10.1007/s10899-017-9698-y

54. Syvertsen, A., Kristensen, J. H., Browne, M., Li, E., & Pallesen, S. (2023). Validation of the 7-Item Domain-General Gambling Harm Scale (DGHS-7). *Addictive Behaviors Reports, 17, 100499.* https://doi.org/https://doi.org/10.1016/j.abrep.2023.100499

55. Ford-Gilboe, M., Wathen, C. N., Varcoe, C., MacMillan, H. L., Scott-Storey, K., Mantler, T., Hegarty, K., & Perrin, N. (2016). Development of a brief measure of intimate partner violence experiences: the Composite Abuse Scale (Revised)—Short Form (CAS-SF). *BMJ Open, 6(12), e012824.* https://doi.org/10.1136/bmjopen-2016-012824

56. Adams, A. E., Greeson, M. R., Littwin, A. K., & Javorka, M. (2020). The Revised Scale of Economic Abuse (SEA2): Development and initial psychometric testing of an updated measure of economic abuse in intimate relationships. *Psychology of Violence, 10(3), 268-278.* https://doi.org/10.1037/vio0000244

57. Dowling, N., Smith, D., & Thomas, T. (2009). A preliminary investigation of abstinence and controlled gambling as self-selected goals of treatment for female pathological gambling. *Journal of Gambling Studies, 25(2), 201-214.* https://doi.org/10.1007/s10899-009-9116-1

58. The Australian Psychological Society. (2014). *Ethical guidelines relating to clients at risk of suicide.* https://psychology.org.au/for-members/resource-finder/resources/ethics/ethical-guidelines-clients-risk-of-suicide

59. Eriksen, J. W., Fiskaali, A., Zachariae, R., Wellnitz, K. B., Oernboel, E., Stenbro, A. W., Marcussen, T., & Petersen, M. W. (2023). Psychological intervention for gambling disorder: A systematic review and meta-analysis. *J Behav Addict, 12(3), 613-630.* https://doi.org/10.1556/2006.2023.00034

60. Pfund, R. A., Ginley, M. K., Kim, H. S., Boness, C. L., Horn, T. L., & Whelan, J. P. (2023). Cognitive-behavioral treatment for gambling harm: Umbrella review and meta-analysis. *Clin Psychol Rev, 105, 102336.* https://doi.org/10.1016/j.cpr.2023.102336

61. Yakovenko, I., Quigley, L., Hemmelgarn, B. R., Hodgins, D. C., & Ronksley, P. (2015). The efficacy of motivational interviewing for disordered gambling: systematic review and meta-analysis. *Addict Behav, 43, 72-82.* https://doi.org/10.1016/j.addbeh.2014.12.011

62. Maynard, B. R., Wilson, A. N., Labuzienski, E., & Whiting, S. W. (2018). Mindfulness-based approaches in the treatment of disordered gambling: A systematic review and meta-analysis. *Research on Social Work Practice, 28(3), 348-362.* https://doi.org/10.1177/1049731515606977

63. Pfund, R. A., Peter, S. C., Whelan, J. P., Meyers, A. W., Ginley, M. K., & Relyea, G. (2020). Is more better? A meta-analysis of dose and efficacy in face-to-face psychological treatments for problem and disordered gambling. *Psychol Addict Behav, 34(5), 557-568.* https://doi.org/10.1037/adb0000560

64. Pfund, R. A., Peter, S. C., McAfee, N. W., Ginley, M. K., Whelan, J. P., & Meyers, A. W. (2021). Dropout from face-to-face, multi-session psychological treatments for problem and disordered gambling: A systematic review and meta-analysis. *Psychol Addict Behav, 35(8), 901-913.* https://doi.org/10.1037/adb0000710

65. Guyett, A., Merkouris, S. S., Keshani, A., Rodda, S. N., & Dowling, N. A. (2025). *Clinical consensus statements on effective psychological interventions for gambling treatment: A Delphi study with clinicians. [Manuscript in preparation]*

66. Keshani, I. M., Merkouris, S. S., Guyett, A., Rodda, S. N., & Dowling, N. A. (2025). Clinical consensus statements on change techniques for gambling treatment: A Delphi study with clinicians. *J Behav Addict, 14(1), 430-444.* https://doi.org/10.1556/2006.2025.00004

67. Keshani, I. M., Merkouris, S. S., Rodda,S. N., Abbott, M., Aubin, H-J., Bellringer, M. E., Berman, A. H., Billieux, J., Bowden-Jones, H., Browning, C. J., Carlbring, P., Castrén, S., Chamberlain, S. R., Christensen, D. R., Demetrovics, Z., Derevensky, J., Fernandez-Aranda, F., Gainsbury, S., Ginley, M. K., Griffiths, M. D., Håkansson, A., Hodgins, D. C., Jackson, A., Jimenez-Murcia, S., King, D. L., Landon, J., Luquiens, A., Molander, O., Nilsson, A., Odlaug, B. L., Potenza, M., Thomas, S. A., Whelan, J., Dowling, N. A. (2024). *Clinical consensus statements on intervention content for gambling treatment: A Delphi study with clinical researchers. [Manuscript submitted for publication].*

68. Bijker, R., Booth, N., Merkouris, S. S., Dowling, N. A., & Rodda, S. N. (2022). Global prevalence of help-seeking for problem gambling: A systematic review and meta-analysis. *Addiction, 117(12), 2972-2985.* https://doi.org/10.1111/add.15952

69. Goslar, M., Leibetseder, M., Muench, H. M., Hofmann, S. G., & Laireiter, A. R. (2017). Efficacy of face-to-face versus self-guided treatments for disordered gambling: A meta-analysis. *J Behav Addict, 6(2), 142-162.* https://doi.org/10.1556/2006.6.2017.034

70. Saxton, J., Rodda, S. N., Booth, N., Merkouris, S. S., & Dowling, N. A. (2021). The efficacy of personalized normative feedback interventions across addictions: A systematic review and meta-analysis. *PLoS One, 16(4), e0248262.* https://doi.org/10.1371/journal.pone.0248262

71. Tracy, K., & and Wallace, S. P. (2016). Benefits of peer support groups in the treatment of addiction. *Substance Abuse and Rehabilitation, 7(null), 143-154.* https://doi.org/10.2147/SAR.S81535

72. Schuler, A., Ferentzy, P., Turner, N. E., Skinner, W., McIsaac, K. E., Ziegler, C. P., & Matheson, F. I. (2016). Gamblers Anonymous as a recovery pathway: A scoping review. *J Gambl Stud, 32(4), 1261-1278.* https://doi.org/10.1007/s10899-016-9596-8

73. Sirola, A., Savela, N., Savolainen, I., Kaakinen, M., & Oksanen, A. (2021). The role of virtual communities in gambling and gaming behaviors: A systematic review. *Journal of Gambling Studies, 37(1), 165-187.* https://doi.org/10.1007/s10899-020-09946-1

74. Beck, A. K., Forbes, E., Baker, A. L., Kelly, P. J., Deane, F. P., Shakeshaft, A., Hunt, D., & Kelly, J. F. (2017). Systematic review of SMART Recovery: Outcomes, process variables, and implications for research. *Psychol Addict Behav, 31(1), 1-20.* https://doi.org/10.1037/adb0000237

75. Rogers, J. (2023). The place of mutual help groups in supporting recovery from gambling-related harm. In J. Landon, Rodda, S., & Zangeneh, M. (Ed.), *Problem gambling counseling and treatment approaches (pp. 259-284). CDS Press.* https://cdspress.ca/wp-content/uploads/2023/11/9_CHAPTER-NINE_Rogers_FINAL.pdf

76. Ferentzy, P., Sanchez, S., & Turner, N. (2019). Technology and mutual aid for problem gambling: The past and the future. *Journal of Concurrent Disorders, 1, 20-30.* https://doi.org/10.54127/USQZ5590

77. Dowling, N., Merkouris, S., Lubman, D., Thomas, S., Bowden-Jones, H., & Cowlishaw, S. (2022). Pharmacological interventions for the treatment of disordered and problem gambling. *Cochrane Database of Systematic Reviews(9).* https://doi.org/10.1002/14651858.CD008936.pub2

78. Hodgins, D. C., & el-Guebaly, N. (2004). Retrospective and prospective reports of precipitants to relapse in pathological gambling. *J Consult Clin Psychol, 72(1), 72-80.* https://doi.org/10.1037/0022-006x.72.1.72

79. Cowlishaw, S., Merkouris, S., Chapman, A., & Radermacher, H. (2014). Pathological and problem gambling in substance use treatment: A systematic review and meta-analysis. *Journal of Substance Abuse Treatment, 46(2), 98-105.* https://doi.org/https://doi.org/10.1016/j.jsat.2013.08.019

80. Dowling, N. A., Merkouris, S. S., & Lorains, F. K. (2016). Interventions for comorbid problem gambling and psychiatric disorders: Advancing a developing field of research. *Addictive Behaviors, 58, 21-30.* https://doi.org/https://doi.org/10.1016/j.addbeh.2016.02.012

81. Frisone, F., Salvatore, S., Federica, S. P., & and Merlo, E. M. (2020). Gambling in adolescence: A narrative review of the last 20 years. *Journal of Addictive Diseases, 38(4), 438-457.* https://doi.org/10.1080/10550887.2020.1782557

82. Suomi, A., Watson, N., & Butterworth, P. (2022). How many children are exposed to at-risk parental gambling in Australia? Results from a representative national sample. *Addictive Behaviors, 130, 107305.* https://doi.org/https://doi.org/10.1016/j.addbeh.2022.107305

83. Suomi, A., Lucas, N., Dowling, N., & Delfabbro, P. (2024). Gambling harm experienced by children exposed to parental gambling: An online survey of Australians. *J Gambl Stud, 40(1), 181-200.* https://doi.org/10.1007/s10899-023-10211-4

84. The Australian Psychological Society. (2018). Ethical guidelines for working with young people. https://psychology.org.au/getmedia/f03dfc38-c839-4fab-95af-1b16557742c3/ethical-guideline-young-people.pdf

85. Grall-Bronnec, M., Sauvaget, A., Perrouin, F., Leboucher, J., Etcheverrigaray, F., Challet-Bouju, G., Gaboriau, L., Derkinderen, P., Jolliet, P., & Victorri-Vigneau, C. (2016). Pathological gambling associated With aripiprazole or dopamine replacement therapy: Do patients share the same features? A review. *Journal of Clinical Psychopharmacology, 36(1).* https://journals.lww.com/psychopharmacology/fulltext/2016/02000/pathological_gambling_associated_with_aripiprazole.11.aspx

86. Bansal, N., Rogers, J., & Roberts, A. (2025). The prevalence of gambling and gambling related harm in individuals with neurodevelopmental disorder (NDD): A systematic review. *Journal of Gambling Issues.* https://doi.org/https://doi.org/10.4309/aqpe6351

87. The Australian Psychological Society. (2016). *Ethical guidelines for psychological practice with clients with an intellectual disability.* https://psychology.org.au/for-members/resource-finder/resources/ethics/ethical-guideline-psychological-disability

88. Dickins, M., & Thomas, A. (2016). *Gambling in culturally and linguistically diverse communities in Australia. Australian Gambling Research Centre.* https://aifs.gov.au/research/research-snapshots/gambling-culturally-and-linguistically-diverse-communities-australia

89. Whiteside, M., Heyeres, M., Maltzahn, K., Griffin, T., & MacLean, S. (2020). Intervening in Indigenous gambling: A systematic review of the literature. *SAGE Open, 10(3), 2158244020947441.* https://doi.org/10.1177/2158244020947441

90. Adam, S., Nance, T., Sankovic, B., Warda, A., & Albistur, N. (2020). *Culturally responsive framework to address gambling related harm. Western Sydney Community Forum.* https://wscf.org.au/wp-content/uploads/2021/04/Culturally-Responsive-Framework-to-Address-Gambling-Related-Harm.pdf

91. Blank, L., Baxter, S., Woods, H. B., & Goyder, E. (2021). Should screening for risk of gambling-related harm be undertaken in health, care and support settings? A systematic review of the international evidence. *Addiction Science & Clinical Practice, 16(1), 35.* https://doi.org/10.1186/s13722-021-00243-9

92. Monreal-Bartolomé, A., Barceló-Soler, A., García-Campayo, J., Bartolomé-Moreno, C., Cortés-Montávez, P., Acon, E., Huertes, M., Lacasa, V., Crespo, S., Lloret-Irles, D., Sordo, L., Clotas Bote, C., Puigcorbé, S., & López-Del-Hoyo, Y. (2023). Preventive gambling programs for adolescents and young adults: A systematic review. *Int J Environ Res Public Health, 20(6).* https://doi.org/10.3390/ijerph20064691

93. Keen, B., Blaszczynski, A., & Anjoul, F. (2017). Systematic review of empirically evaluated school-based gambling education programs. *Journal of Gambling Studies, 33(1), 301-325.* https://doi.org/10.1007/s10899-016-9641-7

94. The South Australian Centre for Economic Studies. (2019). *Evaluation of YourPlay: Final report. University of Adelaide.* https://apo.org.au/node/277096

95. Lund, I. (2009). Gambling behaviour and the prevalence of gambling problems in adult EGM gamblers when EGMs are banned. A natural experiment. *J Gambl Stud, 25(2), 215-225.* https://doi.org/10.1007/s10899-009-9127-y

96. Bijker, R., Booth, N., Merkouris, S. S., Dowling, N. A., & Rodda, S. N. (2023). International prevalence of self-exclusion from gambling: A systematic review and meta-analysis. *Current Addiction Reports, 10(4), 844-859.* https://doi.org/10.1007/s40429-023-00510-6

97. Parke, J., Parke, A., Harris, A., Rigbye, J., & Blaszczysnki, A. (2015). Restricting access: Self-exclusion as a gambling harm minimisation measure in Great Britain. *The Journal of Gambling Business and Economics, 8, 52-94.* https://doi.org/10.5750/jgbe.v8i3.1032

98. Goh, E. C. L., Vincent, N., & and Yeoh, B. S. A. (2016). The family exclusion order as a harm-minimisation measure for casino gambling: the case of Singapore. *International Gambling Studies, 16(3), 373-390.* https://doi.org/10.1080/14459795.2016.1211169

99. Kotter, R., Kräplin, A., & Bühringer, G. (2018). Casino self- and forced excluders' gambling behavior before and after exclusion. *J Gambl Stud, 34(2), 597-615.* https://doi.org/10.1007/s10899-017-9732-0

100. Caillon, J., Grall-Bronnec, M., Perrot, B., Leboucher, J., Donnio, Y., Romo, L., & Challet-Bouju, G. (2019). Effectiveness of at-risk gamblers' temporary self-exclusion from internet gambling sites. *J Gambl Stud, 35(2), 601-615.* https://doi.org/10.1007/s10899-018-9782-y

101. Orford, J., Templeton, L., Velleman, R., & Copello, A. (2005). Family members of relatives with alcohol, drug and gambling problems: A set of standardized questionnaires for assessing stress, coping and strain. *Addiction, 100(11), 1611-1624.* https://doi.org/10.1111/j.1360-0443.2005.01178.x

102. Goodwin, B. C., Matthew, B., Matthew, R., & and Rose, J. (2017). A typical problem gambler affects six others. *International Gambling Studies, 17(2), 276-289.* https://doi.org/10.1080/14459795.2017.1331252

103. Dowling, N. A., Spence, K., Browne, M., Rockloff, M., & Merkouris, S. S. (2025). Affected other prevalence and profiles: Findings from a cross-sectional Australian population-representative gambling study. *Journal of Gambling Studies.* https://doi.org/10.1007/s10899-025-10377-z

104. Dowling, N. A., Hawker, C. O., Merkouris, S. S., Rodda, S. N., & Hodgins, D. C. (2025). Addressing gambling harm to affected others: A scoping review (Part I: Prevalence, socio-demographic profiles, gambling profiles, and harm). *Clinical Psychology Review, 116, 102542.* https://doi.org/https://doi.org/10.1016/j.cpr.2025.102542

105. Dowling, N. A., Hawker, C. O., Merkouris, S. S., Rodda, S. N., & Hodgins, D. C. (2025). Addressing gambling harm to affected others: A scoping review (part II: Coping, assessment and treatment). Clinical Psychology Review, 116, 102543. https://doi.org/https://doi.org/10.1016/j.cpr.2025.102543

106. Orford, J., Jenny, C., Neil, S., & and Bowden-Jones, H. (2017). Stress, strain, coping and social support for affected family members attending the National Problem Gambling Clinic, London. *International Gambling Studies, 17(2), 259-275.* https://doi.org/10.1080/14459795.2017.1331251

107. Browne, M., Newall, P., Rawat, V., Tulloch, C., Rockloff, M., Li, E., Hing, N., Russell, A., & Begg, S. (2022). *The Gambling Harms Scales: Instruments to assess impact to gamblers and affected others that are benchmarked to health utility. Victorian Responsible Gambling Foundation.* https://responsiblegambling.vic.gov.au/documents/1206/RES0118_The_Gambling_Harms_Scales.pdf

108. Patford, J., & Tranent, P. (2013). With due consideration: Australian human service practitioners' understandings of confidentiality and disclosure obligations in regard to cases concerning gambling-related theft. *International Journal of Mental Health and Addiction, 11(1), 31-49.* https://doi.org/10.1007/s11469-012-9397-y

109. The Australian Psychological Society. (2015). E*thical guidelines on confidentiality.* https://psychology.org.au/for-members/resource-finder/resources/ethics/ethical-guidelines-on-confidentiality

110. The Australian Psychological Society. (2021). *APS ethical guidelines for reporting abuse and neglect, and criminal activity.* https://psychology.org.au/for-members/publications/inpsych/2020/dec-jan-issue-6/aps-ethical-guidelines-for-reporting-abuse-and-neg

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