Perspectives on implementing a chat service prior to roll-out

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Abstract

Oasis is an organisation run by the Salvation Army, that provides free counselling and support services for those affected by the harm of gambling. Currently, traditional face-to-face counselling and phone counselling are the main avenues of support provided by Oasis. An online chat service is being added to provide an additional access point for clients. This research focuses on their clinician's experience throughout the implementation process and will include their perspectives, potential concerns, or benefits to the webchat-based service. The participants for the study where all clinicians currently employed by Oasis who were being involved in the initial training and roll out of the chat service.

The data for this study was gathered through a focus group with the clinicians prior to the implementation of the chat function, with thematic analysis used to analyse the data. Current research regarding clinicians' views towards new avenues of support tend to focus on online video therapies or telehealth, particularly with the COVID-19 pandemic. The study provides insights into the clinicians' perspectives and how the implementation process can be adapted in order to improve the clinician's experience. Recommendations are also made in relation to future training for new clinicians, further support for current clinicians as well as future research.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university of institute of higher learning.

Signed: _____ _____

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Chapter One: Introduction and Literature Review

This study aims to explore clinicians experience during the implementation process of an online chat function for brief interventions in a problem gambling service. Braun and Clarkes' (2006) thematic analysis will be used in order to identify common themes between the different clinician's experiences. This study seeks to extend current research regarding clinicians' experience with the implementation of new mediums, particularly within a problem gambling setting.

Issue and Context

Current research regarding differing mediums of therapeutic intervention tends to have a focus on telehealth, e-health, or video-based counselling services; particularly with the rise of online interventions throughout the COVID-19 pandemic. Within the problem gambling setting however, when research is gathered, the data gathered often surrounds patients experience with different mediums rather than that of the clinician or service provider. Oasis, a gambling harm support service offered by the Salvation Army, offers free counselling and support for those effected by the harm of gambling. Traditionally, support is provided through face-to-face, phone and group counselling (Salvation Army Oasis, 2021). The launch of an online web-chat function is a new avenue to provide support for those effected by the harm of gambling, as well as an additional avenue for clients to seek support. A key part of the implementation is understanding the concerns, benefits and needs perceived by clinical staff who will be involved in delivering chat-based counselling. As outlined in this literature review, most of the current literature surrounds the engagement and the outcomes of the interventions, rather than the clinician's experiences.

This study seeks to identify common themes within the experiences of clinicians at Oasis who are involved in the initial implementation of the online chat function. A qualitative approach will be used due to the exploratory nature of the research question. This in turn enables the researcher to obtain insight into the clinician's experiences in order to gain a greater understanding of their world and understandings (Austin & Sutton, 2014).

Gambling Disorder

Gambling Disorder (GD), also commonly referred to as compulsive gambling, pathological gambling, or a gambling addiction, involves repeated problematic gambling behaviours. These behaviours share several clinical similarities with substance use disorders and substance dependence. The DSMV outlines GD as persistent and problematic gambling behaviours that lead to clinically significant impairment and distress. These behaviours include repetitive or compulsive engagement in said behaviours despite the adverse consequences, needing to gamble with increasing amounts of money in order to achieve the desired excitement, restlessness and irritability with attempts to decrease or cease gambling, a history of unsuccessful attempts to cut back, control or stop gambling, diminished control, an urge or craving state prior to engaging in the problematic behaviour and a hedonic quality during the engagement in the problematic behaviour (American Psychological Association [APA], 2013). The DSMV also outline lying to conceal extent of gambling, jeopardizing or loosing significant relationships, jobs, educational and career opportunities as a result of the gambling, relying on others to provide money to relieve desperate financial situations as a result of gambling, gambling when experiencing feelings of distress as well as feelings of preoccupation with gambling (APA, 2013).

Similar to the DSMV the ICD-10 refer to problem gambling as pathological gambling, a disorder where preoccupation gambling and the excitement experienced with increased risk (World Health Organisation [WHO], 1993). While the DSMV and the ICD-10 share many clinical features, many suggest that the DSM allows for better research classification of GD with the clearly outlined diagnostic features, whereas the ICD-10 allows for greater clinical discretion when making a diagnosis (Tyrer, 2014). When classifying problem gambling, the DSM IV classified GD as an impulse control disorder, with the DSMV classifying GD as a Substance-Related and Additive Disorder since being reclassified as disorder gambling, compared to pathological gambling (APA, 2013; Tyrer, 2014). The ICD10 however, categorise problem gambling as a Habit and Impulse control Disorder (WHO, 1993).

While it is estimated that globally GD affects between 0.2 to 5.3% of adults, Hodgins et al (2009) note that these figures should be treated with caution given the wide range of screening tools and measures that are used to diagnose GD. While ideally all screening and assessment tools are based on the appropriate theoretical principles, constraints such as

funding and time limitations, often lead clinicians to seek the most practical and accessible tools. There are a range of different screening tools that can be used to assess both risk and severity of GD. Some tools, such as the South Oaks Gambling Screen (SOGS), NORC Diagnostic Screen for Gambling Problems, DSM-5 Gambling Disorder Criteria and Inventory of Gambling Situation (IGS) are designed as clinical tools, assisting in diagnosis and measures of severity. Other screening methods, including the Brief Biosocial Gambling Screen (BBGS), the Problem gambling Severity Index (PGSI) and the Early Intervention Gambling Health Test (EIGHT Screen) are designed as broader public health tools to assess issues at a population level as well as measuring and assessing levels of risk of problematic behaviours. These tools all use a range of different diagnostic features and severity measures, therefore suggesting that while one screening tool may measure an individual to be at high risk and severity for GD, another may screen the same individual as medium risk of severity GD (Bellringer et al., 2008).

Gambling in New Zealand

In New Zealand it is estimated that approximately 75% of the general population gambled within the last 12 months (Abbott, 2018). Forms of gambling in Aotearoa range from purchasing Lotto or scratch tickets, raffle tickets or sweepstakes, horse or dog racing, betting on sporting events, gaming machines at pubs or clubs, housie or bingo for money, gaming machines at casinos, table games at casinos and internet or phones games for money (Tu, 2013; Thimasarn-Anwar et al., 2017). Therefore, a large majority of New Zealand adults can gain access to gambling on their smart phone, their local pub or TAB as well as a casino. Throughout the 1980's and 1990's, 80% of gambling expenditure was on track betting, with the remaining 20% lotteries. However, with the establishment of casinos and online gambling platforms, including online lotteries, in 2012 approximately 78% of New Zealand's gambling expenditure was buying lottery tickets and only 16% of through track or sports betting.

The harm caused by gambling is globally on the increase, particularly with the rise of online gambling platforms (Gambling Report, 2018). The Gambling Act 2003 was established in order to regulate gambling in New Zealand, with the aim of preventing and minimising the harm caused by gambling in Aotearoa. Under the Act, the Ministry of Health

(MoH) is responsible for the prevention and treatment of problem gambling, in turn, making problem gambling a public health issue (Gambling Act 2003). The Health Promotion Agency (HPA) have then been contracted to with raising public awareness as well as developing support resources for problem gambling.

Studies suggest that the use of online gambling platforms is increasingly growing in popularity, with an increase in usage of 13% in 2020, with the usage expected to rise by up to 50% in 2021 (Stewart, 2021; Te Pou, 2020; Ministry of Health, 2021). In New Zealand, Lottery and scratch tickets, such as Lotto and Instant Kiwi are said to be the most common form of gambling and have been since with 1990's (Abbot, 2018). In 2012 it was highlighted that 80% of New Zealanders took part in 1-3 different gambling activities, with 22 participating in 4 or more activities. These activities included lottery tickets, raffle tickets, scratch tickets, pokies and electronic gaming machines (Abbott, 2015). While many New Zealanders gamble infrequently and without harm, a small portion of New Zealanders gamble in such a way that puts both them and their family in the way of harm.

Currently in Aotearoa New Zealand it is anticipated that approximately 2.7% of the population meet the criteria for low-risk gambling on the Problem Gambling Severity Index (PGSI), 1.2% or approximately 36,700 people, meeting the criteria for moderate-risk gambling, and 0.7%, around 22,8000 people, meeting the criteria for problem gambling (Thimasarn-Anwar et al., 2017). It is important to note that low-risk gamblers may experience some degree of harm or negative consequences as a result of their gambling, as it is considered low-risk, not zero-risk. Within the New Zealand population, it is estimated that males are more likely to regularly partake in gambling, such as lotto, track betting, sports betting, or casino tables than females, and are up to 7.5 times more likely to be problem gamblers than females (Rossen, 2015). It is also suggested that females where more likely to access help services than males.

Results from the 2016 Health and Lifestyles Survey suggest that around 4.6% of New Zealand adults have experienced some level of harm from their gambling (Thimasarn-Anwar et al., 2017). These figures align with the National Gambling Study, which suggests around 4.6% of New Zealand's population in 2015, and 2.9% in 2012, where at low-risk of experiencing harm from gambling, and with 1.7% and 1.8% respectively being moderate-risk gamblers (Abbott et al., 2018). While these statistics may be considered relatively low for the general population, Schull (2014) noted that almost half, 49%, of those who gambled

or used gambling machines at least monthly at pubs or casinos were found to be at high-risk, with approximately 1 in 4, or 26%, of those who bet on sports or racing at least monthly were considered to be high-risk gamblers.

Second-hand gambling harm refers to the effects that of someone's gambling on the wider family or household. This can include an argument directly or indirectly caused by gambling behaviours or going without something, including necessities like food as a result of the gambling. In 2018 1 in 14 New Zealand adults reported experiencing second-hand gambling harm in the last 12 months, with 1 in 5 New Zealand adults being affected by the harm of gambling in their lifetime (Thimasarn-Anwar et al., 2017). The Health and Lifestyles survey suggested that while second-hand gambling harm tends to be decreasing, approximately 6% of New Zealand adults reported experiencing at least one form of household level gambling harm, with 12% reporting experiencing harm from a friend or family members gambling (Thimasarn-Anwar et al., 2017).

Interventions for Problem Gambling

Multiple interventions and treatments have been investigated regarding the effectiveness of treatment for GD (Hodgins et al., 2009). These different interventions include behavioural therapies, brief interventions, third wave therapies and systemic approaches; like family therapies (Hodgins et al., 2004; Hodgins et al., 2009; Quilty, 2019). Behavioural therapies and third wave therapies, including Cognitive Behavioural Therapy (CBT), are beneficial treatment approaches for problem gambling. Given that CBT has a focus on replacing the underlying unhealthy, irrational, negative beliefs, and thoughts with healthy, positive beliefs and cognitions, it is considered my many to be an effective intervention for GD (Hodgins et al., 2009; Quilty, 2019). Hodgins et al (2004) noted that in their study, those with GD who underwent a 6-week course of CBT showed a decrease in gambling, and in some cases a complete cessation of said behaviours. In a follow up of Hodgins et al (2004), Hodgins et al (2009) noted that those who underwent behavioural based therapies and CBT, continued to show a decrease, or cessation, in pathological gambling behaviours after a 24 month follow up. Behavioural therapies using systematic exposure to the problematic behaviours that are to be unlearned are also considered to be a beneficial intervention for GD as they aid in

teaching skills to reduce urges and desires to gamble (Hodgins et al., 2009). Given the extent of second-hand gambling harm, family therapies are also highlighted as beneficial treatment options for GD (Hodgins et al., 2004).

Brief interventions (BI) are typically a one-on-one conversation, or informal counselling session, held between a clinician and a client where knowledge and information is shared by the clinician in order to raise awareness of the harm the problematic behaviours are causing. BIs often include motivational interviewing, problem solving and goal setting with the client. While a more recent form of treatment, BIs are increasingly being used for problematic gambling and addictions. Brief interventions are noted to be particularly beneficial as an early intervention for problem gambling (Quilty et al., 2019). Quilty et al (2019), noted that in a study where those who were considered low to moderate risk of gambling disorder, brief interventions where as effective as longer more active interventions as no significant difference was shown between the two. Similarly, Abbot et al (2013) concluded brief interventions delivered via a telehealth service where able to provide a reduction in problem gambling severity, as measured by the PGSI-3. Therefore, it can be suggested that brief interventions are effective in reduction of problem gambling behaviours. Given the nature of brief interventions, they can be easily adapted from an in-person counselling to other mediums, including phone counselling or through an online platform (Quilty, 2019). Hodgins et al., (2001) noted that when providing brief intervention and motivational interviewing via telephone, clients where more likely to seek further counselling in order to reduce problematic behaviours.

Several studies suggest that brief interventions and motivational interviewing where effective in reducing gambling frequency and showed comparative results to longer term interventions such as CBT (Hodgins et al., 2004; Hodgins et al., 2009; Quilty, 2019). CBT usually involves weekly therapy sessions that generally last between 6 to 12 weeks, a brief intervention however generally involves a single session of psychotherapy. Therefore, given the demonstrated similarity in outcomes and their ability to reduce problematic gambling behaviours, brief interventions can be considered a more time and cost-effective treatment.

Barriers to Seeking Treatment

While there are a range of different services available for problem gamblers, a majority do not seek or participate in treatment (Monaghan & Blaszczynski, 2009). Dabrowska et al

(2017), note that many individuals engaging in problematic gambling are unable to recognise or acknowledge their problematic behaviours. Recent studies suggest that almost three quarters of problem gamblers have never sought professional assistance, counselling or engaged in any forms of self-help (Dabrowska et al., 2017). With some studies suggesting as little as 10-20% of the population with gambling disorders partake in any form of treatment (Dabrowska et al., 2017). Given the small percentage of those engaging in services, Volberg et al. (2006) found that a majority sporadically seek help from two or more different services before engaging in long-term treatment. Dabrowska et al. (2017), compared populations who experienced problematic gambling with those experiencing alcohol or drug dependence, concluding that while there where similar barriers to engaging in treatment, many of those currently in treatment for their gambling originally sought help for other mental health issues or drug and alcohol dependence.

Pulford et al (2008) looked at the perceived barriers to seeking help for problem gambling in New Zealand through a gambling help line. It was suggested that there are multiple barriers to seeking help but pride, shame and denial where the most commonly reported barriers. These barriers where highlighted by both gamblers within the general population who were not seeking help, and those who were seeking help through the helpline. While the reason for low engagement in interventions and treatments are largely unknown and varies from person to person, Monaghan and Blaszczynski (2009) suggests the low engagement is due to treatment options not meeting the anticipated needs or requirements of individuals. Often the low social knowledge surrounding gambling disorders, and a poor perception of gambling within society is also viewed as a contributing factor (Monaghan & Blaszczynski, 2009). Gainsbury and Blaszczynski (2011), note that an important factor for many when seeking help for problem gambling is anonymity, which in turn can help with potential stigma and shame, as well as addressing privacy concerns. Hing and Russell (2017) outline that perceived stigma and discrimination regarding problematic gambling behaviours create a barrier preventing or delaying problem gamblers from seeking help.

When compiling research as to why problem gamblers delayed seeking help, or did not seek help, Suurvali et al. (2009), suggested that the most reported barriers where the desire to handle the issues by oneself, intense feelings of shame, embarrassment and stigma, unwillingness to admit they were experiencing a problem as well as issues towards the treatment itself. Cooper (2001) also highlighted barriers to treatment involving unwillingness

to admit they required help to handle their gambling, stigma and shame, particularly given the social stigma surrounding problem gambling.

Through the National Gambling Report Abbott et al (2008) highlight ethnicity as a key indicator for risk of problem gambling in Aotearoa as well as a barrier to seeking help. International research highlights particular ethnic and cultural groups, for example Chinese, and ethnic minorities and indigenous groups, including Māori experience higher rates of gambling (Raylu & Oei, 2004). Globally, indigenous populations have higher problem gambling rates than non-indigenous populations (Robertson et al., 2005). Through the National Gambling Survey, Abbott et al., (2008) note that Māori and Pacific populations in Aotearoa have higher rates of problem gambling, and appear to be some of the highest reported rates internationally. While over represented in rates of problem gambling, it is noted that Māori tend to under-utilise gambling treatment services in relation to their need. Dyall and Hall (2003) argue that Māori are more likely to underutilize services for help due to feelings of whakama (embarrassment), aligning with the barriers to treatment highlighted by Pulford et al (2008).

Evidence suggest that in order to reduce barriers for Māori to access help, development of culturally appropriate and relevant services and programs are the key to increased engagement and stronger retention (Huriwai et al., 2000). Huriwai et al (2000) suggest that an effective treatment with limited barriers would integrate western practices within a tino rangatiratanga (self-determination) framework alongside approaches which emphasise the values, beliefs and practices of Māori. Robertson et al (2005)., suggest that Māori are more likely to engage and retain in treatment, even with non-Māori practitioners, when they feel as though their cultural needs are incorporated into treatment.

While not specific to problem gambling, Owens et al. (2002), suggests barriers for youth when seeking help included barriers such as time, costs, and travel, as well as the personal barriers of feeling overwhelmed, lack of confident or inability to recognise the exact problem. Given these issues arising with traditional face-to-face treatments, internet-based interventions may overcome these accessibility barriers. Linke et al., (2007) found in a sample of problem drinkers accessing online interventions, 39% of participants accessed the service between 6.00pm and 9.00pm. Linke et al., (2007) suggests that the substantial proportion of participants accessed help outside of traditional working hours, which were

later indicated to be the times when the participants experienced higher levels of distress and tended to engage in problematic behaviours.

Alternative Interventions for Gambling Disorder

With the range of different interventions being highlighted as effective interventions for GD, providing new avenues to treatment could be considered one way to mitigate common barriers to accessing help. Globally online therapeutic interventions are on the rise, with several different internet-based interventions for problem gambling available (van der Maas et al., 2019). With the stigmas surrounding problem gambling and the poor social perception of problematic gamblers, many delay seeking help or avoid seeking help altogether due to the feelings of shame brought on by the stigma (Rodda et al., 2018).

Web-based counselling has the potential to minimise or potentially eliminate these barriers (Rodda et al., 2013). It is worth noting that many of the participants engaging in online therapies for their problem gambling were suggested to also have comorbid disorders, such as social anxiety, that were preventing them from seeking treatment. This in turn suggests that providing an online service helped to mitigate the barriers that prevented or delayed many from seeking traditional face-to-face therapies (Rodda & Lubman, 2014). Similarly, Cooper (2001) noted that online therapies for GD had the ability to decrease the practical issues around attending treatment, such as transportation issues and counselling being offered during traditional business hours.

Rodda et al. (2018), looked at providing a new avenue for problem gamblers to access support that was not previously available. When implementing an SMS support service, participants reported a significant decrease in problematic gambling behaviours over a 12-week period, it was also noted that there were significant retention rates from the 198 participants involved (Rodda et al., 2018). Furthermore, it was noted that 10% of the participants who used the SMS support service sought immediate phone counselling as a result from the SMS support, with many other participants later gaining access to face-to-face counselling services.

Chebli et al. (2016) concluded in a systematic review surrounding internet-based interventions for addictive behaviours that online modalities can achieve positive behavioural

changes, with online interventions having the ability to provide effective and practical services for those who would previously not seek help for their problematic behaviours. Unfortunately, face-to-face counselling for substance use disorders and problem gambling tends to have high rates of treatment drop out (Chebli et al., 2016). In turn, online web-based counselling was found to be particularly beneficial as the treatment-dropout rates tended to be lower (Rodda et al., 2018; Chebli et al., 2016).

Research tends to suggest that problem gamblers typically do not present themselves to in-person services until their gambling behaviours have led to several complications including severe financial issues, martial or family issues and employment issues (Dowling et al., 2015). Given the extensive range of barriers to seeking treatment in person, many people who are accessing online or telephone-based help services are found to be new to treatment and have not sought in person treatment in the past (Rodda & Lubman, 2014). It is also suggested that with online therapies, the cliental tend to be younger and male; differing to the trends found by in person services (Rodda & Lubman, 2014; Dowling et al., 2015). This indicates that online therapies help to engage with populations that are often difficult to reach and use the available services. When discussing with clinicians the population they may think online based therapies will attract, it was suggested by the clinicians that online therapies may attract those who are socially isolated and may not seek help until their gambling has become problematic (Rodda & Lubman, 2014). Online therapies were viewed to be a key instrument of early interventions as they had the ability to access clients who would have traditionally delayed or avoided seeking help (Schuster et al., 2018; Chebli et al., 2016).

Clinicians' Perspectives on Online Therapies

Shuster et al. (2018) surveyed licenced psychotherapists on their perceived advantages and disadvantages to online or blended therapy. It was found that many therapists displayed guarded and negative attitudes towards computer-based therapies, which in turn hindered the dissemination of this medium of assistance. Schuster (2018) suggests from the surveys that extended support from management and further training regarding these adapted therapies from the workplace may be beneficial in influencing the therapist's perspectives in a positive manner, making them more willing to engage in the different mediums. This suggests that gauging clinicians' attitudes throughout the training and implementation of the webchat may

be largely beneficial for both the training and upskilling of professionals using the service, as well as for the roll out of similar programmes within other organisations and services.

Machluf et al. (2021), specifically focused on therapist's experience with conducting online interventions through the COVID-19 pandemic. Similar to Shuster et al. (2013), Machluf et al (2021), concluded that with a supportive workplace, therapists tended to have an open and positive perspective towards the different style of intervention. This in turn, had the clinicians believing that the therapy could have an overall positive impact on the clients (Machluf et al., 2021). Machluf et al (2021) noted that these positive experiences for the clients where a defining factor in the therapists overall positive experience and attitude towards working in an online setting and made them more open to introducing different therapeutic mediums into the workplace in the future.

Wood et al. (2021) outline that online therapies and chat services are becoming an essential medium for providing interventions to meet the growing demands for digital mental health support. This has been particularly highlighted through the COVID-19 pandemic. Through their study Wood et al (2021) noted that practitioners were eager to learn the required skills to adapt their current skillset to suit the online mode, even if the specific training options for the platform were limited. The study from Wood et al (2021) highlighted the key themes that were present when asking clinicians about their experience with using a chat-based service as platform-specific training, communicative adaptions or changes to their language, risk management and practitioner support. In turn, it was suggested that platform-specific skills would allow the practitioners to rapidly build, manage and maintain therapeutic relationships and manage risk in the online setting; the key concerns expressed by the clinicians.

Benefits to Online Therapies

Online therapies and interventions provide a series of benefits for both the service providers and service users. Rodda et al. (2013) highlighted a recent uptake in web-based counselling within a problem gambling setting in an Australian population. When enquiring with participants why web-based methods were chosen over more traditional modes, 27% of the 233 participants reported using services for their confidentiality factors, 50.9% for the

convenience and accessibility, 34.2% recognised the ease of access to the service while 26.6% accessed web-based services as this was their preference of therapeutic medium (Rodda et al., 2013). Rodda et al. (2017) investigated the effectiveness of a single-session web-based intervention for problem gambling. This study highlighted that out of the 229 participants, there was a significant increase in the overall participants confidence to resist the urge to gamble, as well as decreased distress caused by these urges. This study therefore concluded that single-session web-based therapy can be beneficial for problem gamblers. This study used self-reported data from the service receivers and did not consider the service providers perspectives and confidence towards ability to perform web-based therapies.

While there are several known benefits for the service users, internet-based treatment options also provide a range of benefits for service providers including an improvement in safety, particularly when clinicians are working alone or outside of standard business hours, and a broader range of clients who can access the service; including those who may live in more remote areas or have transport and logistical barriers to attending counselling (Gainsbury & Blaszczynski, 2011; Chebli, 2016). Gainsbury and Blaszczynski (2011), concluded through their review that online interventions for gambling and addictions where able to provide effective treatment, and where able to help members of the community who would not have previously sought help due to these barriers.

Mullin et al., (2016) compared motivational interviewing being conducted online versus in person, while evaluating a clinician's experience using the two different mediums. Mullin et al., (2016) concluded that it is feasible to conduct motivational interviewing in an online format, as it tends to be just as effective as the in-person version. Clinicians' experience of providing motivational interviewing through an online format found that they believed they were able to provide an effective intervention, with many viewings motivational interviewing training should include providing the required skills to provide it in an online format as they were able to encourage behavioural changes through the online format (Mullin et al., 2016). However, Mullin et al (2016), noted that out of the 34 clinicians who participated in the study, many where unlikely to self-report any issues in using the online version of motivational interviewing and therefore using objective measurements or key performance indicators to measure clinician's performance and ability to use the online format was more beneficial and accurate.

Disadvantages to Online Therapies

While the list of benefits to online therapies is extensive, there are also several disadvantages that should be considered; particularly in regard to the clinicians' experiences. When working within an online setting there are also several legal and ethical considerations that need to be accounted for. Counsellors, psychologists, and social workers are all required to abide by their governing bodies codes of ethics that are to be followed when working in Aotearoa, New Zealand. The New Zealand Psychological Society (NZPsS) for example outlines a Code of Ethics for psychologists working within Aotearoa/New Zealand (NZPsS, 2012). With the online therapies being conducted in cyberspace, this can in turn push regulations and jurisdictions as cyber therapy has the potential to cross international borders, in turn meaning some clinicians may then be working outside their jurisdiction (Griffiths & Cooper, 2003).

Foxhall (2000) highlights issues with obtaining informed consent and the security of patient data with online therapies, nothing that when working with a patient in a face-to-face setting, clinicians have the ability to ensure the patient truly understands what is being consented too; in comparison to online therapies where this may not be possible. Therefore, under the NZPsS Principle 1.7, clinicians are at risk of breaching the Code of Ethics as they may not have gained informed consent to provide interventions (NZPsS, 2012). Similarly, Principle 2 of the NZPsS Code of Ethics outlines that clinicians are to provide responsible caring, thereby working competently and within their scope of practice.

Griffiths and Cooper (2003), highlight the potential for deception with online therapies. Through this study, it was highlighted that counsellors may not always be aware of their client's true identity and need to be wary of assumptions made about their clients. Griffiths and Cooper (2003) note that therapists do not have the ability to rely on client's presentation (including their age bracket and other demographics) and therefore must base the counselling solely on the information provided by the client. They then suggest that some counsellors may have difficulty adapting to this different situation. Griffiths and Cooper (2003) also emphasize the difficulty in responding to high risk or problems that are very severe via the internet and therefore should be treated with caution. Griffiths and Cooper (2003) suggest that workplaces provide their clinicians with an outlined protocol of how to handle high risk clients in order to support their practitioners. While it is noted that online therapies through chat services will not

solve everybody's problems, online services provide the ability to provide support that many will find beneficial (Griffiths and Cooper, 2003).

With the lack of face-to-face contact involved in a chat service, the loss of non-verbal communication such as body language, voice volume and tone of voice can be influential on the therapeutic session (Cooper, 2001). The loss of these communication tools can alter the interaction between the client and the therapist leading to miss diagnosis or lack of further referrals. However, Cooper (2001) note that through the development of skills gained through adequate training and practicing providing online therapies, these issues have the ability to be mitigated as the clinicians become more skilled. Cooper (2001) also notes that that these skills largely involve the differing language used by the counsellors when working in an online forum in comparison to a face-to-face setting. This language is said to develop, and counsellors become more confident in using the differing language overtime.

When discussing with counsellors their concerns with providing online therapies, Griffiths and Cooper (2003) noted the concern for loss of therapist contact. This was described as the ability for the client to leave mid therapy, whether by choice or through technology failure. When this loss of interaction is by choice, in an anonymous service the counsellor does not have the ability to ring or check on their client's safety, and in a larger service where there may be several counsellors operating, there may not be the ability for the client to reconnect with the clinician they had previously spoken with.

Rational for Study

Research suggests that the biggest barriers to seeking help for problem gamblers are shame, fear and denial. Many report calling a helpline or asking for help in person to be an overwhelming and daunting task that delays or prevents them from seeking help all together. Oasis, an organisation run by The Salvation Army, intend to roll out an online chat based service that will assist in overcoming these barriers, providing a wider out reach into the community.

Currently, a majority of research surrounding clinicians experience with using different platforms for brief interventions tends to focus on telehealth services, or increasingly, video-

based therapies such as Zoom therapy through the COVID-19 pandemic. This study aims to gain an understanding of clinicians experiences through the implementation of an online chat service that will be supplementary to their current face-to-face and phone based services.

Chapter Three: Methodology

This chapter begins with my reasoning for using a qualitative approach, followed by details regarding the participants, data collection and analysis methods. Potential concerns regarding quality, ethics and rigour will also be discussed.

Qualitative Design

Qualitative research allows for analysis of descriptive texts; therefore, allowing to gain a deeper grasp of lived human experiences in the context of their natural environment. Qualitative research is a form of investigation that provides a framework, allowing for exploration of organisational procedures, human perceptions, and experiences in peoples natural environment. It also allows for insight into obstacles and enablers to change and therefore can be considered appropriate for research in health and psychology (Starks & Trinidad, 2007). Therefore, the qualitative approach is the most appropriate avenue for research where an investigation is looking into humans' perceptions and how they are influenced by different factors, including as organisational influences, culture, attitudes, and personal experiences (Malagon-Maldonado, 2014).

The aim of this research was to provide an in-depth account of the Oasis clinicians experience in using a new medium for brief intervention with the implementation of the web-chat service. With the increase in online therapeutic interventions, online therapies, and telehealth services, particularly through the COVID-19 pandemic, there is an increase of research into the effectiveness of these alternative avenues of services. However, currently there is limited research into clinicians' perspectives of these different therapeutic mediums and their beliefs regarding the effectiveness and quality of the counselling and support that can be offered through an online web-chat service. In order to gain more insight into these viewpoints, the clinicians who will be providing the chat service will be asked a range of open-ended questions. These questions will cover potential benefits of the service they perceive, extra training from their employer they may see valuable, their perceptions of what clients/clinicians the approach will suit, as well as potential concerns they have towards the medium will help to gain a wider understanding of what may impact the therapeutic tool.

Therefore, a qualitative methodology was the best approach for the study given the nature of the research question.

Originally, the data for this research was to be obtained in two stages. First, through a focus group prior to training and familiarisation with the platform, and then 6-8 weeks later through semi-structured interviews with clinician participants as they develop skills and experience. This would have allowed for any changes to be highlighted and knowledge and experiences process, as can be fed into the training process for future staff. The extended Covid-19 lockdown in Auckland caused delays in the training for the webchat as well as the integration of the chat function on the Oasis website. The chat function also experienced delays in engagement, which therefore meant many participants had not been able to use the service on a regular basis; a key aspect of the second phase of data collection. Therefore, the decision was made to only use the focus group for data collection.

Participants and Recruitment

The sample for this project was comprised of a relatively small number of participants (n=8), these participants where all current employees of the Salvation Army's Oasis, for those concerned about the harm of gambling. After approval was obtained from AUT Ethics Committee (AUTEC) (Appendix 1) potential participants were recruited via an email sent by an employee at Oasis and were provided the information regarding the research. All participants where either trained counsellors, psychologists or counselling psychologists and their participation remained voluntary throughout. The participants then contacted the researcher via email after being provided with the participant information sheet (Appendix 2). The inclusion criteria were that all participants where clinicians currently working for the Salvation Army, Oasis and were going to be trained and working as a clinician via the chat function. No participants where a part of the senior management team to avoid any potential bias and not all staff at Oasis elected to be a part of the study. No information regarding the basic demographic of participants was gathered in order to maintain anonymity given the small sample size. The participants then signed consent forms before taking part in a focus group conducted on the video-based conferencing platform, Microsoft Teams.

Procedure

In order to ensure the aims of the research were met, it was important to use a method that allowed the research to attain such goals given the framework. Therefore, using a focus group with a set of semi-structured questions complimented the qualitative research approach and allowed for the exploration of attitudes, experiences, and beliefs (Sandelowski, 2000). The use of a focus group for the initial data collection method also allowed for open discussions between the participants. This in turn allows for some ideas and themes to be elaborated on, while the development of concerns can also be developed through the discussion. The focus group included five topic specific questions, with the possibility for further follow-up questions or relevant discussions to take place. These topic specific questions were provided to the clinicians in advanced via email (see Appendix 3) and included the questions regarding clinicals training needs, questions regarding aspects affecting the clinician individually as well as their wider team and where then followed by questions regarding concern for their clients and the service users. This allowed the participants to be informed of the topics (and consider them ahead of time) that would be covered during the focus group.

The focus group was completed on Teams, a video conferencing platform that the participants where all familiar with. In order to ensure the interviews were reasonably structured and the questions remained well formatted and appropriate for a qualitative study, an interview schedule (See Appendix 4) containing the prospective questions was used. The participants were also provided with these proposed questions. While the interview schedule was used as a guide, some questions were adjusted throughout the focus group due to participants responses; however, the five key questions provided to the participants where followed. A range of different reflection and exploratory questions were used throughout in order to gather clarification and elaboration from the participants whenever necessary. This helped to encourage the participants to answer the questions in a way that best suited them, and to ensure any areas that were considered important where able to be thoroughly explored. Up on completing the focus group, participants were able to email any further points or additional comments.

Data Analysis

Given the qualitative nature of the study, thematic analysis was the chosen method of data analysis. Thematic Analysis (TA) was chosen for the data analysis and is a process that allows for the identification and analysis of themes within a data set. TA provides a flexible approach of analysis that allows for connections, similarities and parallels discovered between participants to be examined further (Braun & Clarke, 2006). TA was also considered to be the most appropriate approach given it was the first time the researcher had undertaken qualitative research and this methodology allowed for exploration of ideas while reinforcing the skills that were required for qualitative analysis.

Braun and Clarke (2006), outline 6 phases of analysis that are to be followed when completing TA. These include familiarizing oneself with the data, searching for themes, reviewing themes, defining, and naming said themes and producing a report. These steps allow for identifying, analysing, and summarising themes within a dataset; organizing the data and giving the researcher the ability to code and describe the dataset in detail. While there is strong emphasis to the importance of going back and forth through the data set, Braun and Clarke (2006), note that these do not identify themselves, and are up to the analyser's interpretation.

Phase one of TA, as suggested by Braun and Clarke (2006) involved the focus group being transcribed verbatim by the author. This allows for familiarisation with the data and preliminary noting down ideas. Phase two involved the generation of codes from the thought-provoking ideas and features throughout the data set as a whole, relating these features and ideas back to the focus area of the research. Once the coding was completed, themes and subsequently subthemes where able to be produced based on the organisation of these codes (Braun & Clark, 2006). A thematic map is then produced in order to create a clear structure that outlines the themes and subthemes identified within the data set. Throughout the process, this map outlining the different themes was adjusted several times as other phases where undertaken; Braun and Clarke (2006) note that each step does not require completion before continuing on with the next step. Furthermore, descriptions and names were provided for each theme and subtheme in order to highlight the important areas of each theme in relation to the research question. Finally, appropriate quotes were taken from the transcript of the focus group and aligned with each theme and subtheme. These quotes are then used to help illustrate the

findings, particularly in answering the research question as well as relating the findings to existing literature.

Ethical Considerations

Ethical implications and considerations were accounted for throughout the development of this study. Given that human participants were involved in the study, to guarantee participant safety, ethical approval was applied for and received through the Auckland University of Technology Ethical Committee (AUTEC). Ethics approval was granted on the 21st of June 2021 under reference 21/164 (see Appendix 1).

Prior to data collection, participants were provided an information sheet regarding their involvement in the study, as well as the purpose of the research; given the study was intended to be held in two phases, participants were provided with an information sheet for the focus group (see Appendix 3) as well as for the one-on-one interview at the end of the focus group. Consent forms were provided to the participants alongside the participant information sheet, outlining the purpose of the study and how the findings would be presented. As a part of the consent form, participants agreed to keep information confidential, however, as there was a very small participant pool who are all colleagues, full anonymity for the participants was not able to be guaranteed. The participants were advised that the focus group would be recorded and transcribed verbatim, as well as how this information would then be stored and kept in accordance with requirements.

Given the nature of the study, it was highly unlikely that participants would suffer from any discomfort, disturbance, or harm throughout the process, particularly given the voluntary nature of the study. The participation in the research project remained voluntary throughout the process, with the opportunity for the participants to withdraw from the study at any point without the need for any explanation. The researcher acknowledges that the participants are the experts in their field and therefore their experience and perceptions are of extreme value to the research and its implications on future practice and research.

As this research was conducted in Aotearoa New Zealand it therefore honours the principles of the Treaty of Waitangi, Ti Tiriti o Waitangi. The researchers engaged in several

planning meeting with the Oasis leadership team and staff, as such partnership is intrinsic in all aspects of this work, its essence is truly collaborative and is a service-oriented project. Semi-structured focus groups allowed the participants to share their ideas and expertise in a less restricted manner, to clarify their perceptions in depth. The participants will be invited to clarify and add anything to the transcripts from the interviews if they so wish in order to guarantee autonomy and ownership of the participants.

Chapter Four: Findings

This chapter will describe the findings that were produced through the process of thematic analysis. Three overarching themes were identified through the analysis of the data set:

1. Differing Engagement
2. Organisational Influences
3. Subjective Capabilities

Each of these overarching themes where then comprised of several subthemes that aided in illustrating and providing a deeper understanding of the clinician's experiences.

Theme One: Differing Engagement

A reoccurring concept throughout the focus group involved the new forms of engagement that it was hoped the chat function would bring. This was viewed by many of the participants as a benefit to themselves and their prospective clients, as well as Oasis as an organisation. When asking the clinicians their perceived benefits for themselves, many responded with benefits for their clients or the service itself as they believed the chat function held the ability to increase their outreach population. Three subthemes were determined as reoccurring aspects relating to the differing or new demographics for engagement, these included the wider outreach, engaging with those effected by second-hand gambling harm and increased accessibility.

Subtheme: Wider Outreach

Throughout the focus group, a majority of the clinicians expressed a benefit of the chat function being the ability to engage with new clients by providing a wider outreach. It was expressed by several clinicians that they had hoped that the new medium of providing service would attract a younger client base by giving the clients a medium that they are more familiar with. It was also noted that younger clients tended to want assistance without having to wait:

We'll engage with those we often don't reach… I think the younger clients will be attracted to the immediacy of it, they don't like to wait. They can talk to someone then and there about it, in a forum or medium that they are used to.

One participant expressed that many people note hesitancies towards the Salvation Army as an organisation and question what it could provide. It was then noted that the anonymity factor of the chat function allows for the potential clients the opportunity to see what help can be provided with little effort and commitment:

It gives the clients more choice of how they want to communicate… Some people are wary of the Salvation Army and think 'okay, this is the Salvation Army I want to check this out first.' The chat function gives them the opportunity to do this.

Another participant then noted that it is not uncommon for people to also express reservations or hesitancy towards counselling in general. In comparison to traditional face-to-face interventions, the chat function allows potential clients to briefly try the service online, allowing them to then make an informed decision as to when and where they choose to seek help:

Some people have reservations about counselling and such, this allows them to check that out first. So again, that's about giving clients some choice, a real benefit that is not necessarily been available to them yet.

Subtheme: Second-hand Gambling Harm

It is predicted that approximately 1 in 14 New Zealanders will experience the second-hand harm of gambling in their lifetime. Services, like Oasis, aim to provide support to those engaging in problematic gambling, while also providing support to those affected by the second-hand harm of gambling. Second-hand gambling harm includes a broad range of issues, from arguments or fights as a result of someone's gambling behaviours, to going without necessities as a result of the gambling. By providing support to those with the problematic behaviours and their family, a more holistic, systemic approach can be taken to provide assistance.

One participant described their view that Oasis would receive more engagement from those affected by the harm of second-hand gambling through the affected family members, and their enthusiasm for being able to offer broader support:

I believe we will get more engagement from affected family members, wanting to know what is out there... not only for the gambler but for their affected family members. I strongly believe that there is not a lot of information out there with the support for affected family members. I'm excited to be able to take a more rounded approach and help the families.

While one clinician highlighted that they hoped the chat function could provide help for the affected family members, another similarly noted that when with working with family members, help was wanted immediately or in the moment which may be a possibility with the chat function.

Family members can be, umm, not really equipped to deal with the addict, and it could become a tool for them to check in and see how to deal with a situation, cause, you know, some of the experience I've had with affected others is that they just don't know how to deal with the situations at the time, so it could be so beneficial as a "help, how do I approach this" kind of service, in real time.

While not all participants mentioned the potential engagement with affected family members, this theme was mentioned by four of the participants throughout the focus group in the context of potential new cliental for engagement and therefore was an important subtheme within differing engagement.

Subtheme: Increasing Accessibility

While several benefits outlined by the clinicians involved the ability to attract new demographics of clients and educate a wider population, accessibility was another common theme that was brought up both directly and indirectly throughout. One participant expressed that often full-time workers, including mothers, struggle to access services due to the constraint of their opening hours. The chat function could aid in mitigating this issue by ensuring support could be available whenever needed.

One of the people that we might be reaching that we haven't yet, I think, might be people who work full time, the people who cannot get in when we work. This includes women who work full-time, full-time Mums. That's a whole new demographic that we haven't covered yet that I can see this working for.

Another clinician expressed that many of their clients also struggled with comorbid disorders, such as anxiety and panic disorders. Therefore, providing a different medium for support and interventions may help to mitigate potential barriers to seeking treatment they may present. It was proposed by one participant that this may help them to form a therapeutic relationship or sense of trust with those clients who may traditionally struggle to seek treatment. The chat function can be viewed as a stepping-stone to get these potential clients into more long-term counselling.

We have so many clients who really struggle to get out of the house, they will be truly benefited by it. Those with severe anxiety. This will be a great way to build that trust, to eventually get them in the door and engaging with the help they need.

While The Salvation Army and Oasis offer a range of services, including their food bank service, one clinician expressed their eagerness to be able to engage with a new population through the webchat that may not have the financial or transport ability to reach their in-person services.

Even those who do not have the funds to come into one of our centres or to go places, this can be the outreach they need to access our range of service…. I often reach out to new cliental in line at our foodbank, this may help reassure those who cannot get there or feel a range of negative emotions that it is okay to ask for help, to get the help they need.

It was conveyed by one participant that each clinician aimed to see each client for no more than one session per week. It was then noted that the chat function, while giving the ability for each clinician to increase their number of sessions with the hoped increased engagement, also allowed clients to seek additional assistance in between sessions on an as and when needed basis. Therefore, the chat allows for those clients who are more dependent or needing extra support during the week to check in and seek help, either anonymously or logged

in, with a clinician. This factor was noted as both a positive and negative factor for the clinicians.

Theme Two: Organisational Influences

Different aspects surrounding organisational influences such clinician's workload, Key Performance Indicators (KPIs) and training, were periodically mentioned throughout the focus group. Many participants expressed the chat function held the potential to have both positive and negative effects different work-related aspects. The theme of organisational influences encompasses any influences on the clinician's experience that are seen at an organisational level, therefore including workload, performance indicators and training provided by Oasis.

Subtheme: Performance Indicators

Key Performance Indicators (KPIs) are used to measure performance over a period of time for a specific objective, ultimately having the ability to demonstrate how effectively the clinicians are able to achieve their required objectives. Session targets were mentioned throughout the focus group, one clinician expressed that the webchat would help them to reach their required targets. This was possible as the chat provided the opportunity to share the workload across the country with the clinicians in the smaller centres able to assist with online clients who would typically require service from one of the larger centres.

I see this as being a great way to help us reach our targets. As someone previously said, it can spread the workload across the centres… we might be able to boost our numbers a bit and help us keep our jobs.

Subtheme: Workload

Several participants expressed the potential changes the chat function could bring to their workload. These changes could then be categorised as both short term and long-term changes. In regard to their initial workload, it was articulated that there was extensive training involved in addition to their current requirements:

How is this going to fit into our workload? Given that it is a new thing that we need to fit in on top of what we already do.

Similarly, another participant noted the initial increase of workload. This participant noted the potential requirement of practicing on their weekend off in order to ensure they were fully equipped and prepared for the training and monitoring of the chat service:

We need to spend time reading the manual and going through it. Practicing on Saturdays, Sundays? We really need to spend time going through it all. It might be a struggle for us here and there

While there was concern expressed by some participants towards initial changes to their workload given the initial training and practicing requirement, some participants then expressed concern towards a long-term increase in their workload. While for many this increase in workload assisted in reaching their performance targets, there was concern expressed towards working extra hours on top of their traditional hours.

It's going to increase our workload, it's a whole extra set of clients to work with, it's another set of skills that will require further practice and training. We might even be working outside of our standard hours.

Subtheme: Anxiety about Training

With the focus group being held prior to the training, a reoccurring theme that was raised throughout involved the upcoming training. With many comments and questions surrounding the training, it became apparent that some clinicians felt confident in their skills and ability to adapt to the new mode, while others expressed uncertainty in the training that was to be provided. This was to be expected given the training was yet to be undertaken.

I've seen the training manual. There's just so much involved with the training. It's going to take some getting used too. Where do we even start?

With the uncertainty towards the training, many clinicians raised concern with the learning of what seems like a new language as well as the skills required. One clinician in particular noted that while they felt confident in their ability in their skills in an in person setting or over the phone, they were anticipating that the training would cover the required coaching to be able to adapt their skills to the online medium.

It's like learning a new language, but I'm hoping the training will cover everything we need to know. We all have the skills; it's just knowing how to use them. I don't think it'll be too different, but we won't know till we undergo training, we won't know till we try.

Theme Three: Subjective Capabilities

Given the focus group being held prior to the implementation of the chat function, the majority of participants expressed differing concerns for themselves, their colleagues, or their clients. These concerns and uncertainty largely surrounded the aspects that seemed to be unsure or apprehensive about. The subjective capabilities could then be broken down into three key subthemes; the clinician's ability to assess and respond to risk, uncertainty towards the safety of their clients and their ability to adequately use the adapted language required with the chat function. There was some recognition of 'learning by doing', and that clients early in the roll out might receive a service that has yet to develop fully.

I do feel quite apprehensive, uncertain if you will. And so, the person that I get in a month might actually be better off than the person I have tomorrow because I will be better off. I guess that is just too bad. I have them now, I'm starting now, so that's what they get.

Subtheme: Risk

Risk was a common factor that many of the participants expressed feelings of uncertainty and concern towards. Risk can be defined as a client being a threat to themselves

or those around them; this includes suicide risk or being at risk of relapse or imminent violence. Several concerns were raised regarding risk, including one's ability to assess risk via the webchat service, the ability to work with high-risk clients in an unfamiliar medium, working with clients who are at risk without the ability to assess or know their support system, location, and physical wellbeing. One clinician noted:

I guess we cannot respond to risk so easily… I mean, it might turn out that they are at risk and then we're kind of sitting here and they're sitting who knows where… so there's that.

While the ability to assess risk was raised as a concern, the ability for the clinicians to debrief and work through difficult clients who are at risk was also raised. With one clinician expressing their concern to working with clients who are at risk, noting the importance of debriefing after a difficult session. It was then raised that this may not be possible when working remotely or at home while monitoring the chat service.

When working with someone at risk, it can be so difficult on us. When we're working in the office, we usually have someone right there that we can debrief with... you know? But what if we're working by ourselves or from home. That would be quite hard on ourselves.

Subtheme: New way of communicating

Several clinicians expressed concern for the different language that may be required when providing brief interventions through the different medium. When working in a written form, participants expressed that they believed an adapted language and way of communicating would be required in order to provide an effective treatment. While they were required to use an adaptive communication style, it was also raised as a potential challenge to interpret a client's language:

Learning how to type and communicate with these people, it's like learning a new language… making sure that we use a language that reflects us and not a bot… Just learning to read that kind of language, learning to interpret, and read their specific written language. What's being said there between the lines that we all have in front of us?

Another noted broader changes to their ways of working, in this case their reliance on visual language, including the use of whiteboards and illustrations:

For those of us that are visual people and do a lot of our counselling session with a whiteboard and illustrating stuff, that's just not an option anymore. We just don't have the tools or the visual languages that we usually have when we see people face-to-face.

One in particular noted that engaging a different age demographic meant that while they would need to adapt their language to a written form, they may also need to adapt their language to work with a younger cliental:

We have to learn a whole other language just for the young people. The way they communicate will be like learning a whole new language, and that's without having the ability to use their body language.

Subtheme: Response Time

The response time that was able to be provided to clients through the chat service was considered by many clinicians to be a benefit, particularly with engaging a younger cliental or those who would be attracted to the immediacy of the service. However, some participants expressed the possibility of an increased response time to clients during the initial implementation of the service.

It's going to take some time to get used to, to get up to speed. I know I'm not the best typist so I could be quite slow at first… I worry the clients will expect a lot and fast, something I might not be able to do.

While initially it was perceived to be a benefit to the clients to be able to provide instant assistance, rather than as a reflective practice; many of the clinicians also expressed concern that in comparison to many other chat or helpline services, this particular service was not going to be manned by staff 24/7 at the time of implementation.

It's not 24 hours… I'm concerned people can be left hanging, umm, it seems like possibly a major concern for me that it's not 24 hours.

Another clinician, also expressed apprehension that typically responses are given relatively instantly in traditional modes of counselling:

We are not a crisis service. If we're all tied up with appointments and clients and there's more than one person requiring assistance, there could be quite a time lag or delay in answering or helping some people. With face-to-face or even phone sessions we think quickly and, on our feet, to offer a response instantly.

Chapter Five: Discussion and Conclusion

The present study aimed to explore clinicians experience with the implementation of a webchat service to provide brief interventions for those effected by the harm of gambling. It was hoped that this study would aid in gaining a greater insight into clinicians' perspectives and needs while also providing insights into training and requirements for future clinicians. Originally this research was planned to take part in two stages, the first stage being the focus group held prior to the implementation, with part two including follow up one-on-one interviews with the clinicians after training had been completed and the clinicians had provided service through the chat function. However, given the extended COVID-19 lockdown and delays in the uptake of users of the chat function, the findings for this research are based only off of the preliminary focus group. While only the first part of the research was conducted, there were still significant themes found throughout the data when thematic analysis was completed. This chapter will take a further look into the themes in relation to the clinician's experiences, the focus of the research.

Discussion and Summary of Findings

The thematic analysis utilised in this study helped to identify three key themes within the study. The first theme surrounded the engagement, in particular how it was different to their current engagement. Differing engagements was then broken down into subthemes which were highlighted as wider outreach, engaging with those affected by the second-hand harm of gambling, and increased accessibility. Another reoccurring theme throughout the focus group surrounded the subjective capabilities. This included uncertainty towards their ability to assess risk via the chat function, apprehension towards the response time, as well as the different communicative style required when communicating through the chat service. The final theme that was present throughout the focus group was organisational influences. While a broad influence, this includes key organisational factors such as Performance Indicators or targets, training surrounding the skills required for monitoring the chat service and changes to clinician world load. These different themes are all considered influential factors of the clinician's experience throughout the implementation process.

Differing Engagement

The theme of differing engagement was prominent throughout the dataset and was viewed by a positive aspect of the chat service by the participants. With the new medium for brief interventions being provided, there were several suggestions around the demographic of potential new cliental who would engage with the chat service. While it was considered that the chat service would have the ability to attract a younger cliental who were not typically service users at Oasis, it was also discussed that there was hope those who were affected by the second-hand harm of gambling would engage with the service. It was anticipated that with the potential for quick responses from the clinicians, that these different populations where more likely to engage with the service. Overall, increasing the engagement populations was viewed as a positive attribute to the experience as this allowed the clinicians the clinicians to reach a wider community who previously may not have accessed help due to a range of different barriers.

Several clinicians suggested the hope that the chat service would increase the engagement within a younger demographic. They believed this would largely be due to the familiar technologies and convenience factors that the chat service would be able to provide. This suggestion of engaging with a younger demographic due to the adapted technologies was an idea suggested through existing literature. Wood et al (2021) noted that with clinicians who regularly provided e-therapies, they had positive experiences with being able to build therapeutic relationships with teenagers and young adults through the medium, with many of their clients noting the convenience factor and sense of familiarity being the reason they engaged with the service. Linke et al (2007) similarly noted those under 25 expressed preference in engaging with online services. Based on data from the Ministry of Health (MoH) (2021), less than 1% of those who accessed gambling help where under the age of 25, therefore providing a wider range of avenues for intervention and assistance could be a beneficial way at assisting these different age groups.

With the high number of New Zealanders affected by the harm of second-hand gambling, it was stated by several clinicians that the chat function held potential to be able to provide the support to those effected by gambling harm while also support their friends and family members. The clinicians voiced their hope that the chat service would allow for those

effected by the second-hand harm of gambling to engage with support services on a "when needed" basis. This allows the clinicians to be able to offer support in the moment and can be considered a new approach to providing support that was not previously readily available from the service. Currently, there is little research into the use of online services for those experiencing the second-hand harm from gambling, and therefore could be an avenue for future research.

The chat service also helps to remove potential barriers that are perceived by different cultural groups in regards to seeking help. With Māori in particular often avoiding or delaying engaging with services due to whakamana, embarrassment or shame, that may be perceived to be present (Dyall and Hall, 2003). Therefore, the anonymity factor of the chat service can be a benefit increasing the engagement population. Through the focus group it was also determined that there was a possibility the chat service would have the ability to engage with cliental who would previously be unable to or would struggle to attend the service in person. Those who work full time during traditional hours may not be able to access services during their opening hours, as well as stay at home parents or those with anxiety or panic disorders who may be previously unable to access these services, could benefit from the online factor of the service, allowing them to access help from anywhere. This in turn can also be a positive experience for the clinicians as it broadens their outreach population and was also highlighted in studies by Monaghan and Blaszczynski (2009) and Rhodda et al (2013).

It was hoped that with changing the demographic of cliental, that clinicians would be able to broaden their experience in working with different populations. Engaging with a wider outreach was received with excitement and as a benefit for the participants, this in turn helped to make the experience of implementing the chat function a more positive experience. While broadening the demographic that the clinicians where able to engage with was an influential factor on their experience, this in turn brought on a range of uncertain factors that for the clinicians leading to theme two, subjective capabilities. With the chat service providing the ability to engage with a broader range of clients, participants noted that the service held the ability to develop in order to meet the needs of those whom experienced different barriers to help, including mobility issues and privacy issues. The chat service also holds the potential to addressing discrepancies between genders and ethnicities when seeking help. Currently, females are more likely than males to seek help for problem gambling and related issues (Rodda

et al., 2013). Providing a more flexible service with the chat function may encourage groups who previously where less likely to seek help to engage with help services.

Subjective Capabilities

Subjective capabilities encompass the participants personal feelings and experiences regarding their ability to fulfil the requirements of their job. While subjective capabilities were present throughout the focus group, the theme can then be broken into several different subthemes including; the clinicians ability to assess and respond to risk through the chat function, hesitancy regarding their response time to their clients, and uncertainty towards the new language involved in communicating with the clients. These different aspects where all influential in the clinicians' experience as they included areas where further training may be required. While all participants expressed confidence in their ability to assess and respond risk when working with clients in traditional therapeutic settings, several noted that they felt less confident when communicating via the chat service. It was stressed by several clinicians that Oasis is not a crisis service, and generally they would refer high risk users to crisis lines or crisis services wherever possible.

It was also highlighted that the chat service provided a disclaimer to all users before engaging, highlighting that they were not a crisis service and anyone who urgently requires help was provided with the appropriate details. However, given the anonymity aspect of the chat service there may be situations where this is not possible, and safety checks and follow ups are not plausible. Therefore, it a set of screening questions, or a triage service prior to engaging with a clinician could be beneficial to both the service users and providers as this would allow for the high risk clients to be referred through to the crisis line prior to engaging with a clinician.

With the lack of visual and verbal cues where raised as a concern by the participants throughout. Griffiths and Cooper (2003) found similar a theme through their research, which suggested through adequate training and practice, the clinicians where able to adapt their skills to confidently work in an online setting. Given the reoccurring mention of their ability to respond to risk or give a thorough assessment, this was an influential component on the clinicians experience and confidence to perform their personal expectations. Several studies

suggest that when clinicians lack confidence in their abilities, they show poorer work performance and a lack of enjoyment in the workplace (Griffiths & Cooper, 2003; Monaghan and Blaszczynski, 2009). Therefore, allowing for sufficient platform specific training and tools to adapt their current skillset to work in an online setting would help to improve clinician confidence and in turn increase workplace satisfaction. After the focus group was held, platform specific training was to be provided by senior staff members at Oasis. Originally, the study hoped to conduct one-on-one interviews with the clinicians after the training to discuss this experience further, however, given time constrains this aspect of the research was not possible.

When working with clients in a face-to-face or phone-based setting, response time to clients is considered to be relatively instant. Throughout the study the participants expressed their lack of certainty that responses to clients would also be fast through the chat service, particularly when the service is busy. Similarly, to assessing risk, clinicians communicated concerns for the clients that there would delays in responses that the service users were not prepared for, particularly when there were no workers monitoring the chat service. The uncertainty surrounding response time by the clinicians often surrounded the needs of the clients and wanting to provide the most efficient service wherever possible. Similar studies that held an emphasis on web-based services highlighted that when engaging with online help services, users expected instant responses (Finn & Barak, 2010). The potential delay in response time can be encompassed under subjective capability, as some participants noted that there was the potential that there would be the delay in responding, whether this be through their delay in being able to type out a response or being busy with other clients on the chat service. This was highlighted as a different way of working with the potential to need to manage more than one client simultaneously. Therefore, clinical judgement being an important factor as often they will be basing their judgement on different information than they would normally be presented with, including physical or verbal cues. The same participants then noted their hopes that the training would provide the required skills to communicate in a timely manner with the service users, while also increasing their response time through practice.

Several of the different factors that were surrounded by uncertainty for the clinicians could be resolved through sufficient training and practice, including the uncertainty towards the new communication style involved when working with clients. The lack of visual and verbal cues that are available with traditional counselling allows for the clinician to gain a

better understanding as to whether the client comprehends what is being said. With these cues absent, clinicians conveyed concern that if too much jargon was used and the client did not understand what was being said, that they would be more likely to disengage with the service. With the potential with a younger demographic to engage with the chat service, several clinicians raised concerns with ensuring that their language and wording was appropriate and understood by the younger demographic. The new language involved with working in the online settings was a key theme raised by Wood et al (2021), who highlighted the importance of good communication in a therapeutic relationship. Wood et al (2021) suggested that practitioners communicative style adapted through platform specific training and practice and therefore, while a concern for the practitioners at first, this was soon alleviated.

Organisational Influences

The final common theme encompassing clinicians experience is organisational influences. Organisational influences could then be broken down into the subthemes of performance targets, training, and workload. Given that these subthemes are all influential factors on the clinician's experiences throughout the implementation process that stem from Oasis, their requirements and their influence, these subthemes are all considered as organisational influences. These areas where all outlined as being influential to the clinician's experience and provided the ability to guide future training requirements as well as organisational aspects that were required or could be provided as a result of the research.

At the time of the focus group, several participants noted that they were not aware of what the training would comprise of. However, as all participants had received a manual in the days prior to the focus group, some clinicians where aware of the areas of training to come. Throughout the focus group however, as concerns regarding areas of uncertainty where raised, the clinicians often expressed that they had noted these areas down and would ask for further clarification or guidance during the training. Had there been the ability to conduct follow up interviews, further information and experiences regarding the training could have been gathered to gain further clarity regarding future training needs and requirements.

Participants noted that the chat service would initially increase their workload, particularly with the extensive manual and training that would be required before servicing the

chat function. It was presumed by many of the participants that this would require work outside of their usual working hours as this was to be undertaken on top of their usual workload. While these increases were percieved to be pre introduction of the chat service, it is worth noting that two participants acknowledged they would need to spend their weekend or evenings working through the manual in order to feel as though they were prepared for the required training session that was to follow. While these different factors are influential factors on the participants experience and workload, they could be considered short term changes.

Throughout the focus group it was expressed that Auckland was the busiest centre for Oasis, particularly in comparison to the smaller centres of Christchurch and Tauranga. Therefore the clinicians based in these larger centres often noted a busier workload. It was hoped that clinicians outside of Auckland would be able to increase their session count by monitoring the chat service, thus helping to decrease the workloads of those based in busier areas. This in turn also all increases the work load of the smaller centres, helping many of the clinicians to reach their session targets. Therefore, it could be suggested that while the initial increase in workload to undergo the required training may have been viewed in a negative manner, the changes in workload in terms of clinicians being able to meet their session targets in the long run was viewed in a more positive manner.

This ability to share the workload across the different Oasis centres also had an influence on the performance indicators or targets. Performance indicators, like KPIs, are generally a set of targets outlined by the employer to ensure that the workers are meeting the requirements of their job. Throughout the focus group it was noted that participants all had a target for the number of sessions. It was noted that the ability to share the workload across the different centres would aid in increasing session numbers for those in smaller centres. This in turn has the ability to increase the workers performance within the workplace which in turn can lead to longer term benefits for the organisation as a whole, including increased funding.

Research Implications

The findings gathered from this research largely propose that clinicians' experiences are heavily influenced by organisational requirements as well as their personal beliefs and abilities to fulfil these requirements. From this, it is then necessary to examine the achievability

of these requirements, while also ensuring sufficient training and tools are provided to help clinicians to fulfil said obligations. These different factors are particularly important when implementing new modes of therapeutic intervention as these can provide guidance to best support clinicians in order to achieve the most optimal outcomes. The study highlighted that while organisational influences impact clinicians' experiences, their client demographic and personal capabilities have an extensive influence.

From the focus group it was apparent that many of the pressing concerns of clinicians where focused on technical issues, including their ability to respond in a timely manner and balance the chat service within their daily workload. Implicitly, throughout the focus group there where elements of concern from the participants that the skills they held when working in a face to face setting may not transfer through to the online platform. It was noted by the clinicians that they felt confident in their skills when working in their traditional mediums. However, the main concerns that was expressed by several of the participants where their ability to ensure the clients safety and engagement through the chat service. One clinician in particular noted that she often relied on visual tools, such as using a whiteboard, when engaging with new clients, which was not currently an aspect available with the chat service.

The research notes similar themes that are present within existing research, where through flexibility and adjustment, the clinicians are able to improve the delivery of online interventions with platform specific training. Wood et al (2021) note that clinicians are required to adapt their communication techniques, or language, in order to be able to engage with clients and build a therapeutic relationship on different platforms. While many of the clinicians in the study felt confident they would be able to do this with practice, particularly after the training that was to be provided, it is an area of the research that was highlighted as an influential aspect of the experience of the clinicians.

While studies suggest that mental health clinicians are often open to embracing and combining different approaches to treatment, a common hesitancy tends to revolve around whether the new approach is empirically supported (Nolet et al., 2020; Foxhall, 2000). This was not a theme that was present throughout the focus group, as all participants noted excitement and looking forward to the implementation of the chat service as an addition to their service. Therefore, future research encompassing how effective brief interventions via a chat service are in treating problem gambling would be important as this would help to increase

worker confidence (Foxhall, 2000) while also helping to remove any potential ethical issues in regard to providing effective treatments (Griffiths & Cooper, 2003).

Study Limitations

The current study had a number of limitations that need to be taken into consideration. The first major limitation of the study was the method of data collection. Originally, the study was designed to be taken place in two parts; the online focus group followed by a mixture of in person and online one-on-one interviews. However, given the COVID-19 pandemic and extended lockdown in the Auckland region, the in person follow up interviews where not possible. The COVID-19 pandemic also partially delayed implementation of the chat service, while potentially delaying engagement from clients using the chat function. Given the restricted timeline given to the study, these delays meant the data collection method was limited to just a focus group held prior to implementation. Another potential limitation to the study could include that participants were recruited from within the organisation. Therefore, even though management where not present and anonymity was provided as best possible, there is a chance that some answers that were given where bias or not reflecting the full extent of the clinician's experience; it was hoped that the one-on-one interviews would help to mitigate this potential bias.

Thirdly, limitations surrounding the sample size are worth noting. While Vasileiou et al (2008) note that with qualitative research a small and purposeful sample size can be used in order to obtain an information rich data set that reflects the research question, smaller data sets hold the potential limitations with generalizability and validity. However, given the sample was collected from Oasis and included an overwhelming majority of their clinical staff, it could be suggested that the study has adequate internal validity. Sample bias could also be considered a limitation to the study, given the clinicians volunteered for the study rather than being selected at random. It could then be considered that randomised sampling may increase the generalizability of the research (Heckman, 1979).

Future Research Considerations

While this study was able to illustrate themes that where present in previous literature regarding the implementation of online services within an organisation, it was also able to highlight several different avenues for future research. Given the COVID-19 restrictions and limitations that lockdown provided on the study, further follow up interviews with the clinicians would be influential in exploring how these themes may have adapted, developed, or changed throughout the process. However, different areas where highlighted within the focus group the initial training.

While there is extensive literature surrounding implementing new mediums for therapeutic interventions, particularly with the rise of e-therapies during the COVID-19 pandemic, there is a limited number of studies that have a problem gambling focus, particularly in Aotearoa, New Zealand. Given this, further research into clinicians' experiences in the workplace, particularly a problem gambling service in Aotearoa would be beneficial. Further examining the different impacts on clinicians' experience and how influential each factor is using a measure like the Index of Work Satisfaction (Stamps et al., 1978) or the psychological empowerment and job satisfaction measure (Spence Laschinger et al., 2004) would therefore be beneficial.

Future research looking into implementation of new mediums for intervention may also benefit from including demographic influences, such as age, gender, and educational background. This may be particularly valuable as Spence Laschinger et al (2004) noted in many work places there are differences between male and female employees in regard to workplace empowerment, motivation, and job satisfaction. However, given the small sample pool at Oasis, demographic information was not gathered in order to preserve anonymity wherever possible. Similarly, studies surrounding workplace focuses noted that often male employees tended to hold a greater focus on meeting metrics or performance indicators compared to female employees who tended to hold client outcomes in higher regard (Denend et al., 2020; Miao et al., 2017). Therefore, comparing different population or demographics experiences throughout the implementation process could also be an avenue for future research.

With several themes being highlighted through the use of thematic analysis, further research could be conducted into how much of an effect each of these themes had on the clinicians' experiences. For example, it could be examined the extent to which organisational

influences impact clinicians' experiences, and whether these be positive or negative influences. Comparing clinicians' experiences across different organisations may also help to provide more generalisable findings, as organisations such as Oasis, provide frequent training and support for their clinicians which may differ between organisations.

Current literature suggests that similar chat services, while designed for brief interventions, are often used as tools for clinicians to engage with clients for assessment, providing emotional support, therapeutic interventions and gate keeping (Dowling & Rickwood, 2014). Several clinicians in the study noted they expected to be providing brief interventions and emotional support to the service users, which aligns with the current research. However, further research conducted post implementation on what the chat service is used for and whether the training provided was adequate for said usage would be beneficial.

Recommendations for Practice

A positive and successful experience throughout the implementation of an online chat resource for problem gambling is possible where attention is paid to clinicians needs and requirements. The current study suggests that organisational or workplace influences as well as personal capabilities should be considered in order to ensure the best overall experience for the organisation and the clinicians. The introduction of said chat service allows for an increase in the diversity of clients which in turn can have a positive influence on the clinicians work experience while broadening their skillset. Clinicians where optimistic to integrate the chat service into their workload as a supplementary way for the service to engage new clients. Studies like Finn and Barak (2010), suggest that with appropriate training counsellors manning online services believe that their practice is effective and beneficial to cliental. It is also noted that when used alongside more traditional, face-to-face, forms of therapy clinician satisfaction has the ability to increase (Finn & Barak, 2010). Overall, it was noted that the participants perceived the chat service in a positive light, as an opportunity to increase their skill set, particularly once the technical issues with the chat service where overcome through their initial training.

The study highlighted the uncertainty with responding to risk and client welfare via a new medium, this theme is also present through other studies including Wood et al (2021),

where it highlighted that when first using the web-based services many practitioners expressed a lack of confidence in their ability to screen and assess client risk. Similarly, Finn and Barak (2010) suggest that clinicians gained confidence and comfort through sufficient practice and specific training based off of problems that arose. Therefore, it would be suggested that providing clinicians with platform specific training would be beneficial, while also allowing for development and problem specific training when required. Similar studies including Sucala et al. (2013) also highlight the importance of providing clinicians with training in order to improve their confidence and skills. The ability to access transcripts from chat sessions was highlighted as a benefit of the chat service by clinicians, these in turn could be used as a reflective practice to allow for personal development. It is important to note that through the focus group, participants expressed feeling confident in their abilities when working in traditional methods, and highlighted that through the initial training, this confidence would increase. The main concern that was highlighted by the clinicians regarded their concerns over their client welfare.

Conclusion

The staff working at Oasis who were involved in the initial implementation of the online chat service outlined a range of different influences on their experience. The current research showed consistent themes and findings with the existing literature, highlighting the importance for ongoing training and clinician confidence. Overall, clinicians where positive and optimistic about the use of an online chat service to provide brief interventions in a problem gambling setting. Clinicians showed an interest and a preference in integrating the chat service into their workload, using it alongside their current approaches. In particular, it was found that clinicians believed they would benefit using the chat service as a "foot in the door" or engagement technique alongside their current engagement tools, which include offering support at the local food banks and other Salvation Army services. The key findings of the study suggest that participants felt their skills would develop through using the chat service, but highlighted the importance of ongoing training sessions in order to build confidence and support the clinicians.

The study highlighted a range of different impacts on clinicians experience, outlining different personal, organisational and external influences. While there is current literature

surrounding the increase in e-therapy, particularly with the COVID-19 pandemic, present studies highlight the absence of current literature in the context of Aotearoa New Zealand and also in the context of a problem gambling service. Organisationally, this study demonstrates the support provided by Oasis to their staff, who expresses that while they had concerns, many of these concerns would soon be alleviated through the provided training.

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Appendices

Appendix One: Ethics Approval

Auckland University of Technology Ethics Committee (AUTEC)

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21 June 2021

Jason Landon
Faculty of Health and Environmental Sciences

Dear Jason

Re Ethics Application: **21/164 Exploring clinician views and needs during implementation of an online chat option in a problem gambling service**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 21 June 2024.

Non-Standard Conditions of Approval

1. Removal of the offer to return the transcript from the Information Sheet for focus groups and from the focus group schedule as this is not appropriate in a focus group context.

Non-standard conditions must be completed before commencing your study. Non-standard conditions do not need to be submitted to or reviewed by AUTEC before commencing your study.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.

AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: yqy5032@autuni.ac.nz

Appendix Two: Participant Information Sheet

Participant Information Sheet

Date Information Sheet Produced:

23 May 2021

Project Title

Exploring clinician views and needs during the implementation of an online chat option in a problem gambling service.

An Invitation

My name is Ellen Binney and I am a Bachelor of Health Science (Honours) student and the Primary Researcher for the study. You are invited to participate in this qualitative study in which we are exploring your perspectives and needs as a clinician during the implementation of an online chat service at Oasis. The study aims to help identify your needs and concerns and how these may change throughout the implementation process. This study will help provide guidance for future clinicians undertaking the training of the web-based chat function. Your participation is completely voluntary, and you may withdraw any anytime.

What is the purpose of this research?

The purpose of this research is to gain in-depth knowledge into your experience as a clinician throughout the implementation process of the chat function. Focus groups and semi-structured interviews with those involved in the initial implementation of the webchat service are the two key ways data will be gathered. These findings can then be used to address any potential concerns and improve the future training. The findings of this research may be used for academic publications and presentations. Questions will explore the perceived advantages and disadvantages of the service, training needs, and perceptions of use as the chat service is established.

All data will remain confidential and examples used in the final report will use participant ID numbers and not include the name of the participants or give information that would enable to participant to be identifiable.

How was I identified and why am I being invited to participate in this research?

You have responded to an email inviting you to be a participant of this study. All participants in this research will be all clinical staff working at The Salvation Army Oasis, some of whom have had input into the design of this research. You will have the opportunity to reflect on the process of training and implementation and using your clinical skills in this new domain. We hope to have between 6-12 clinicians participating in this research.

How do I agree to participate in this research?

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

To take part in this research, please make direct contact with Ellen Binney, the primary researcher, via email (see below). Any questions regarding the research can also be emailed to Ellen at any point. Once you have agreed, we will arrange a focus group at the Oasis office in Royal Oak for those in Auckland, and via an online platform for those located elsewhere in New Zealand. The semi-structured interviews will also take place at a place in these locations.

You will be provided with a participant consent sheet prior to the focus group and interview that will need to be filled out and returned to the researcher prior to commencing the focus group and interview. Additionally, you will be asked whether you have read the information sheet and consent to take part in the study at the beginning of the focus group and interview. Answering yes to this question will indicate that you have given your consent to participate, and that there has been no coercion or inducement to participate by the researchers from AUT or anyone else.

What will happen in this research?

Participation in this study will take place in two parts. Firstly, a focus group will be conducted with primary researcher (Ellen Binney), as well as the other research participants. This focus group will take place prior to the training provided by Oasis and the webchat function going live. In the focus group, you will be encouraged to share your views, concerns and thoughts towards the chat function. The focus group will last approximately 60 minutes and involve simple questions relating to our topic, and will allow for additional questions if elaboration is required.

Once training has been undertaken and the chat has gone live, a follow up semi-structured interview will take place. For some participants this will be in person at the Oasis offices in Royal Oak, Auckland, for other participants this will take place in a secure online platform such as Zoom or Teams. Similarly, the focus group, the follow up semi-structured interviews will take approximately 60 minutes to complete and will involve a range of similar open-ended questions regarding your experience with the chat function.

During both the focus group and the interview, you will have an opportunity to ask any concerns regarding the research. After the transcription of the recordings, if you wish, we will supply you with a copy of the interview. At this stage you will have the opportunity to amend or remove any information from the transcript. After this stage, your name will be removed from the interview to sustain confidentiality throughout the final report.

What are the discomforts and risks?

We will endeavour to word the interview questions in a clear and respectful manner. Given the nature of the research we do not anticipate any discomfort or risks. You will also be able to withdraw from the study at any time.

How will these discomforts and risks be alleviated?

You can pause or stop the interviews at any time. In addition, you do not have to answer any questions that may cause discomfort.

AUT Student Counselling and Mental Health is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- drop into our centre at WB203 City Campus, email counselling@aut.ac.nz or call 921 9998.
- let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet.

You can find out more information about AUT counsellors and counselling on https://www.aut.ac.nz/student-life/student-support/counselling-and-mental-health

What are the benefits?

Information gathered from this research will help us better understand the views towards the online chat function to those who will be providing the service. These insights can inform the ongoing development of the service and the associated training and support.

This research will also give Ellen the opportunity to complete her dissertation, a compulsory element to her postgraduate degree.

How will my privacy be protected?

Recordings and Transcripts: To maintain your privacy, you will be identified by an ID Number, for example, P (for participant) 01 = P01, that will be used whenever your comments are referred to in the final report. No individual details that might identify you as a participant will be revealed in the study.

Although full anonymity cannot be offered because the researcher will be interviewing you, privacy will be assured as only the researcher and those directly involved in the study will have access to the audio recordings. All data, including transcripts / audio recordings will be kept in a secure locked cabinet on a memory stick inside Associate Professor Jason Landon's AUT office for six years before being destroyed to protect participant privacy.

What are the costs of participating in this research?

There are no financial costs to participating in the study. Your only cost will be time. It is estimated that the interviews will be approximately 60 minutes long.

What opportunity do I have to consider this invitation?

Once you have completed the consent form, we request that the forms be returned to the researchers at the interview. If you have any questions regarding these forms, you are encouraged to contact the research team. Receiving these completed and signed forms acts as your acceptance to participate in this study.

We aim to hold the focus group prior to the commencement of training for the chat function, and therefore hope to receive your request to participate and consent forms by the end of June 2021.

Will I receive feedback on the results of this research?

As a participant you will be provided with a summary report of the findings via email once the study has concluded.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Jason Landon, jlandon@aut.ac.nz, 09 921 9999 extension 7894.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, *ethics@aut.ac.nz* , (+649) 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Ellen Binney, yqy5032@autuni.ac.nz

Project Supervisor Contact Details:

Associate Professor Jason Landon, jlandon@aut.ac.nz

Appendix Three: Indicative Question Handout

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

Exploring clinician views and needs during the implementation of an online chat option in a problem gambling service

Focus Group Indicative Questions

1. What do you see as perceived benefits of the chat function for clients?
    a. What sorts of clients do you see it as especially helpful for?
    b. Where do you see the function sitting in the range of clinical services you provide?
2. What do you see as the benefits of the chat function for Oasis as a service and your own practice?
    a. What types of clinicians/clinical skills might better suit the chat function?
3. What are some disadvantages that you see to the chat function?
    a. What clients/presenting issues might it not work well for?
4. Do you have any concerns regarding the use of chat function?
    a. Potential probes around client identity, severity, continuity of treatment.
5. What do you see as the key training needs to support you in using the function?

Appendix Four: Focus Group Schedule

Exploring clinician views and needs during the implementation of an online chat option in a problem gambling service

Focus Group Schedule

This focus group aims to explore:

- Benefits perceived the chat function will bring to clients, clinicians and Oasis as a service
- Presenting concerns faced by staff, prior to the implementation of the chat function
- What additional training would be beneficial

Focus Group Format:

- Format of the focus-group (open questions, follow up questions and hearing the clinician's views)
- Confidentiality and the limit around disclosures of harm. This applies to myself as well as other participants in the focus groups.
- Information regarding individual clients will not be solicited or used. If any client details are disclosed, they will be removed.
- No right or wrong answers- the aim of the focus group is to hear their views, they are important and they are the experts in their field.
- Withdrawal at any time from the focus group, semi-structured interview or the study as a whole, also allowing the clinicians not to answer any particular questions
- Timing of the focus group (approximately one hour)

Recording of the focus group:

- There will be a digital recording of the focus group, ensure all participants are okay with this
- Report, use of quotations, anonymisation of information
- Check with participants if they have any questions
- Check whether the participants are happy to proceed

Consent

- Obtain signed consent

Indicative structure:

Begin with a brief overview of the focus of the discussion, and introductions.

With each question probe for detail as required.

1. What do you see as perceived benefits of the chat function for clients?
    a. What sorts of clients do you see it as especially helpful for?
    b. Where do you see the function sitting in the range of clinical services you provide?
2. What do you see as the benefits of the chat function for Oasis as a service and your own practice?
    a. What types of clinicians/clinical skills might better suit the chat function?
3. What are some disadvantages that you see to the chat function?
    a. What clients/presenting issues might it not work well for?
4. Do you have any concerns regarding the use of chat function?
    a. Potential probes around client identity, severity, continuity of treatment.
5. What do you see as the key training needs to support you in using the function?

Closing Questions

Provide the participants the opportunity to add anything. For example, "*We have discussed a range of different aspects to this chat function, is there anything else you would like to add?*"

Other Comments/ Questions

- Thank the participants for their time
- Reassure their confidentiality in the research and ask whether there is anything that they would like to not be discussed or quoted in the final report.
- Confirm that a transcript will be available for them to check and clarify
- Check if the participants have any questions or concerns regarding their participation