Reaching Out: Early Identification and Intervention of Gambling Problems among Asian People in Primary Care

FINAL REPORT

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KEY MESSAGES

There are numerous sociocultural barriers for Asian people to seek professional help for mental health and addictions issues, which could delay treatment and allow problems to intensify. General practices, which carries less stigma and shame than secondary mental health services, has the potential to provide a setting for facilitating Asian people's access to interventions.

Through screening 305 Asian adults enrolled in two GP clinics for gambling, other addictions, and mental health problems, the study had found that:

- around one in five Asian respondents were identified as having problems with gambling across a spectrum of severity (8.3% low-risk, 6% moderate-risk and 5.6% problem gambling as measured by *The Problem Gambling Severity Index,* PGSI). Overall, the rate of Asian people with, or at risk of, problematic gambling (19.9%) was 10% to 14% higher than the results from the National Gambling Study (NGS) and the Health and Lifestyle Survey (HLS). In NGS 2012 - 2015 and HLS 2014 and 2016, the rates of problem gambling among Asian adults ranged from 0% to 1.3%, moderate-risk gambling from 1.3% to 2.8%, and low-risk gambling from 3.2% to 5.8%.
- the survey conducted in GP clinics also revealed co-existing issues amongst moderate-risk and problem gamblers, and 2.6% of survey respondents reported that their family members gambled a moderate amount.

These results support the notion that primary care can provide an important setting for early identification of gambling risk and co-existing issues among Asian adults. Harmful gambling is often under-reported by Asian people due to fear of stigma and embarrassment; however, the familiar and trustful setting of general practices can help to reduce Asian people's fear of stigma and facilitate them to disclose their gambling problems.

A stepped care approach was used in this research to deliver early interventions for harmful gambling, other addictions and mental health issues through general practices, ranging from self-management (guided self-help resource), brief interventions (online webinars, Wellness Services) through to specialist services (Asian Helpline, counselling services). The study found that the Asian respondents who had used one or more stepped care services delivered through general practices were people with mild to moderate mental health and/or gambling problems, and had no or limited experiences of seeking professional help previously.

These findings provided some evidence that primary care-based stepped care interventions can increase help-seeking amongst Asian people, especially people with mild to moderate mental health and addictions needs. The stepped care model helps to increase help-seeking by offering greater choices for Asian people to address their holistic concerns. Other ways the study had used to improve Asian people's access to services included: delivering interventions through general practices which is a familiar and trustful setting for Asian people; removing language barriers by providing services in multiple Asian languages; reducing stigma of help-seeking by assurance of confidentiality and anonymity; and reframing the content of community education to focus on wellness and self-care, rather than focusing on problems. Using a combination of strategies, the intervention programme had reached out to a group of at-risk people who might not have otherwise sought help.

Key implications of the research include:

- Stigma is a key barrier preventing Asian people from disclosing their harmful gambling and associated health issues to others. Primary care can provide an important setting for early identification of gambling risk, hazardous drinking, smoking, drug use and other mental health

concerns amongst Asian adults. The familiar and trustful setting of general practices can help to reduce Asian people's fear of stigma and facilitate them to disclose their gambling problems and co-existing issues.

- General practices also have the potential to provide a setting for addressing Asian people's gambling, other addictions and mental health issues. A stepped care approach to deliver early interventions through general practices improves service accessibility by offering greater choices for Asian people to address their holistic concerns. Improved access to primary and community-based services can contribute towards secondary prevention of those at higher risk of experiencing gambling and mental health problems.
- Addressing gambling, mental health and other addiction issues at primary healthcare level can potentially reduce stigma and discrimination attached to these issues, and facilitate early help-seeking for at-risk people who may not have otherwise sought help.
- Developing and delivering culturally and linguistically responsive early interventions through general practices can improve Asian people's access to services.
- Greater collaboration between GP clinics and community health and social service providers can help to develop innovative approaches to health education, promotion and service delivery, which can result in improved health outcomes and efficiency.

EXECUTIVE SUMMARY

The overall aims of this research were to design and evaluate an innovative service model to facilitate early identification of gambling problems and co-existing issues, and to improve access to interventions among Asian people in primary care. The research project has two parts. Part 1 involved conducting a survey to identify the extent of gambling problems, other addictions, and emotional distress amongst a sample of Asian adults enrolled in GP clinics in Auckland. Evaluation of this part of the research was to identify whether primary care can provide a setting for early identification of gambling problems for Asian people.

In Part 2, early intervention resources/services were developed, promoted and delivered through general practices to facilitate Asian people's access to interventions for harmful gambling and mental health issues. A follow-up survey was delivered to 165 participants who had provided valid contact details in the initial survey, to find out if they had used any of the interventions provided, and to assess if there had been any change in their levels of gambling risk and emotional wellbeing since the initial survey. Evaluation of this part of the research was to identify whether primary care can provide a setting for improving Asian people's access to interventions.

Summary of Part 1 research

- A survey was conducted in two GP clinics in Auckland. The target population were Asian people aged 15 and above enrolled in the clinics. A total of 305 completed responses were analysed. Survey results showed that around one in five Asian respondents were identified as having problems with gambling across a spectrum of severity as measured by *The Problem Gambling Severity Index,* PGSI (8.3% low-risk gambling (PGSI 1-2), 6% moderate-risk gambling (PGSI 3-7) and 5.6% problem gambling (PGSI ≥8)). These results were compared with the gambling rates obtained from national gambling studies, the Health & Lifestyle Survey and the NZ National Gambling Study.

- Overall, the rate of Asian people with, or at risk of, harmful gambling (19.9%) found in the study conducted in general practices was 10% to 14% higher than the results from the National Gambling Study and the Health and Lifestyle Survey. In the NZ Nation Gambling Study 2012 -2015 and the Health and Lifestyle Survey 2014 and 2016, the rates of harmful gambling among Asian adults ranged from 0% to 1.3%, moderate-risk gambling from 1.3% to 2.8%, and low-risk gambling from 3.2% to 5.8%.

- The survey in GP clinics had also identified co-existing emotional distress, hazardous drinking and smoking among Asian respondents with moderate-risk or problem gambling. Over half of moderate-risk gamblers (52.9%) reported high or very high levels of emotional distress. Approximately 35.3% of problem gamblers and 27.8% of moderate-risk gamblers reported that they had had six or more drinks on one occasion in the past 12 months, and one in four (23.5%) problem gamblers were smokers.

- These results suggest that primary care can provide an important setting for early identification of gambling risk, hazardous drinking, smoking, drug use and other mental health concerns among Asian adults. Harmful gambling is often under-reported by Asian people due to fear of stigma and embarrassment; however, the familiar and trustful setting of general practices can help to reduce Asian people's fear of stigma and facilitate them to disclose their gambling problems and associated health issues.

- Help-seeking for harmful gambling and other addictions among the survey respondents was very low. Only two respondents had sought help in the past 12 months to reduce or stop gambling,

two had sought help to reduce or stop drinking, four had sought help to stop smoking and none had sought help to stop non-prescription drug use. In comparison, more respondents (20.1%) had sought help for emotional distress, and those with higher emotional distress were more prepared to seek help than those with lower levels of distress. These results indicate that there is a strong need for support to increase help-seeking and early intervention for harmful gambling and other addictions, alongside psychoeducation and support services for affected others in the family. Part 2 research was to explore if primary care has the potential to provide a setting for facilitating Asian people's access to interventions.

Summary of Part 2 research

- A stepped care approach was used in Part 2 research to deliver early interventions for harmful gambling and mental health issues through two GP clinics, ranging from self-management (guided self-help resource), brief interventions (online webinars, Wellness Services) through to specialist services (Asian Helpline, counselling services). A follow-up survey was conducted two to four months after the initial survey to those respondents who had given contact details, to explore whether they had used any specialised services provided, and their satisfaction ratings of any services that they had used.

- The follow-up online survey was sent on August 12, 2021 to 165 participants who had provided valid email addresses and consented to follow-up during the initial survey. Survey Monkey analytics showed that 77% had started the survey within the first few days. However, five days after the follow-up survey was launched, the COVID-19 Delta outbreak had plunged Auckland into lockdown between August 17 and December 3. Delta is a much more contagious variant of coronavirus. In the midst of Auckland's longest COVID-19 lockdown, AFS frontline workers had observed that Asian people were finding this lockdown more challenging than those they had endured previously. There was increased pandemic-related anxiety and mental distress, feelings of isolation and vulnerability, as well as uncertainty and worries about the future. Under these circumstances, taking part in the follow-up survey did not seem to be a priority for the majority of the potential survey participants.

- Due to the prolonged lockdown and the uncertainty about when restrictions in Auckland could be eased, the survey was ended on September 10. Of the 165 emails which were successfully sent, 20 (12.1%) completed responses were received: 88.2% were non-gamblers, 11.8% low-risk gamblers and none were moderate-risk gamblers or problem gamblers. Five out of the 20 respondents (25%) had used specialised services provided through general practices. As the respondents did not represent the full spectrum of gambling severity, an evaluation of the extent of low-risk, moderate-risk and problem gamblers accessing specialised services through general practices was unable to be conducted.

- Preliminary analysis of the five respondents who had used specialised services was made. They were identified as having mild (n=1), moderate (n=3) to very high (n=1) levels of psychological distress as measured by *The Kessler Psychological Distress Scale* (K10), and three of them were also low-risk gamblers (measured by PGSI). The services that they had used included: AFS Wellness Services (4), Asian Helpline (2), counselling services (2) and guided self-help resource (1). The majority were highly satisfied or extremely satisfied with the services that they had used. Looking into their initial survey results, their help seeking sources were more limited: only two had sought help from a family doctor or counsellor for their emotional issues. These early findings provided some evidence that primary care-based stepped care interventions can increase help-seeking amongst Asian people, especially people with mild to moderate mental health and addiction needs.

- There are numerous sociocultural barriers for Asian people seeking support. In particular, seeking professional help for mental health or addiction issues can carry stigma and shame, which could delay treatment and allow problems to intensify. A combination of strategies was used in this research to increase help-seeking and improve Asian people's access to intervention:
    - General practice carries less stigma and discrimination than secondary mental health services. Providing early intervention for harmful gambling through general practices helped reduce stigma of help-seeking amongst Asian people.
    - The stepped care model helped to increase help-seeking by offering greater choices for Asian people to address their holistic concerns.
    - Providing services in multiple Asian languages helped to remove language barriers.
    - Assurance of confidentiality and anonymity helped to reduce stigma of help-seeking.
- Evaluation of the webinar series was done by running live polling questions during each webinar to gather immediate responses from the attendees. Each set of polling questions measured different target outcomes relevant to the presented webinar topic. Attendees answered each question by providing their answers on a 10-point rating scale. The intended outcomes were that attendees would achieve average scores of at least 6 out of 10 in the nine poll questions provided.
- A total of 20 participants attended webinar 1, 22 attended webinar 2 and 16 attended webinar 3. The analysed data showed that after attending the webinars, attendees had:
    - at least moderate understanding of the impacts of harmful gambling
    - at least moderate awareness of the warning signs of harmful gambling
    - a lot of increase in knowledge on how to prevent and minimise gambling harm and where to get professional help
    - the skills for managing stress and self-care introduced in the webinar were extremely helpful.
- After the webinars, webinar presenters reviewed the webinar content and made the following suggestions for consideration in the planning of future webinars:
    - reframing the content to focus on wellness and self-care, rather than focusing on problems; use gambling as a case study to showcase the negative effects
    - Promote the guided self-help resource across multiple channels
    - Pre-recordings and a tracker to see the number of views can give us an idea of reach and allow people to access this content in their own time
    - Avoid delivering the webinars at dinner time – which is usually family time.

Key implications of the research include:

- Stigma is a key barrier preventing Asian people from disclosing their harmful gambling behaviour and associated health issues to others. Primary care can provide an important setting for early identification of gambling risk, hazardous drinking, smoking, drug use and other mental health concerns amongst Asian adults. The familiar and trustful setting of general practices can help to reduce Asian people's fear of stigma and facilitate them to disclose their gambling problems and co-existing issues.
- General practices also have the potential to provide a setting for addressing Asian people's gambling, other addictions and mental health issues. A stepped care approach to deliver early interventions through general practices improves service accessibility by offering greater choices for Asian people to address their holistic concerns. Improved access to primary and

community-based services can contribute towards secondary prevention of those at higher risk of experiencing gambling and mental health problems.

- Addressing gambling, mental health and other addiction issues at primary healthcare level can potentially reduce stigma and discrimination attached to these issues, and facilitate early help-seeking for at-risk people who may not have otherwise sought help.
- Developing and delivering culturally and linguistically responsive early interventions through general practices can improve Asian people's access to services.
- Greater collaboration between GP clinics and community health and social service providers can help to develop innovative approaches to health education, health promotion and service delivery, which can result in improved health outcomes and efficiency.

1. INTRODUCTION

The Government Inquiry into Mental Health and Addiction report (2018) identified the need to transform the primary care sector, with a strong policy focus on supporting primary and community providers to deliver more and different services for people with mental health and addiction needs, particularly people with mild to moderate and moderate to severe mental health and addiction needs. The upcoming health sector reforms also recognise the need to transform the primary healthcare system and to improve equity of access to care (Department of Prime Minister and Cabinet, 2021).

The initiative developed and tested in this research can contribute to this change. In August 2019, Asian Family Services (AFS) gained a research contract funded through the Ministry of Health (MOH) Gambling Innovation Research and Evaluation Fund to develop, deliver, and evaluate new services for treatment and recovery for people at high risk of gambling harm. This report presents the research that was undertaken to develop and test an initiative to enable early identification of harmful gambling and co-existing issues amongst Asian people in primary healthcare settings, and to develop and deliver resources and services to facilitate their access to, and utilisation of, gambling harm minimisation interventions and related professional support services.

1.1 RATIONALE

1.1.1 Harmful gambling is a problematic issue in Asian communities with many barriers to help-seeking

Gambling is a problematic issue in New Zealand's Asian communities. Studies have indicated that the impacts of harmful gambling on Asian people, families and communities include decreased quality of health, declines in work productivity or study performance, emotional and financial stress, relationship breakdown, children being neglected and affected by parents' arguments, borrowing money from loan sharks, engagement in criminal activities, and domestic violence (Keen et al., 2015; Sobrun-Maharaj, Rossen & Wong, 2012; Wong & Tse, 2003). The factors contributing to gambling addiction are multiple and complex. Asian people living in a Western country, especially recent migrants, are likely to be vulnerable to harmful gambling because they face many challenges such as immigration and settlement stress, isolation, loneliness, boredom, language barriers, unemployment or under-employment, and housing and financial difficulties. Many problem gamblers tend to use gambling as a form of escape from their problems (Au & Ho, 2015; Tse, Wong & Chan, 2007).

Although Asian people are at high risk for developing harmful gambling, they are under-represented at treatment services (Gibb & Cunningham, 2018; Ho, 2013; Mehta, 2012; Sobrun-Maharaj et al, 2012). Language barriers, not knowing where to get help, and cultural barriers such as shame and stigma associated with admitting problems and seeking help, have been identified as key barriers to Asian people's access to harm minimisation services and related specialised support services. Research has also found that Asian people with problem gambling mostly seek help from their immediate and extended families, friends, workmates, and employers. They often also turn to their general practitioners (GPs) for physical symptoms or health problems, but view seeking professional help from a counsellor or a psychologist as the last resort (Tse, Wong & Chan, 2007). Accordingly, there is a strong need for initiatives or support to increase help-seeking and early intervention, and these include new models of service delivery within primary healthcare settings.

1.1.2 GP clinics could act as a critical early detection point for Asian people to access wider intervention services

Primary care is the first level of contact of individuals and families with the health system (International Conference on Primary Care, 1978). In recent years, significant policy attention has

focused on integrating service delivery across primary, community, and secondary services (Cumming, 2011). For example, Mental Health Commission's Blueprint II (2012) called for earlier identification of mental health and addiction issues in primary care and proposed a stepped care approach to enable people to move to different levels of care as their needs change, from self-care and across primary, community and specialist services to get the best possible outcomes. This approach creates opportunities for collaboration between GPs, psychiatrists, counsellors, and community workers (Kates et al, 1997, 2018). The report on The Government Inquiry into Mental Health and Addiction (2018) also made recommendations to support primary care providers to develop more accessible services for people with mental health and addiction needs, particularly those in the 'middle ground', i.e., people with mild to moderate and moderate to severe mental health and addiction needs.

Within Asian communities, cultural barriers such as shame and stigma are key barriers to seeking mental health and addiction treatment services (Sobrun-Maharaj et al., 2012). Using primary care carries less stigma and discrimination than using secondary mental health and addiction services. Thus, primary care has the potential to enable earlier detection of gambling and other addiction issues facing Asian people and to improve their access to appropriate services, including secondary services.

The initiative developed and tested in this research involved screening Asian adults for gambling, other addictions, and emotional well-being at GP clinics, and facilitating them to access services across the spectrum of harmful gambling behaviour, rather than just services for problem gamblers only. As such, the initiative broadens the target group for early intervention to include people with low to moderate risk of harmful gambling. This is necessary because "at a population level the majority of harm is accruing to those who are not necessarily problem gamblers" (Browne et al., 2017, p.13). The brief intervention resources developed in this research were designed with relevant cultural materials and delivered in specific Asian languages that could further improve access to services.

1.2 RESEARCH OVERVIEW

The overall aim of this research was to design and evaluate an innovative service model to facilitate early identification of gambling problems and co-existing issues, and to improve access to interventions among Asian people in primary care (mainly GP clinics). The research project has two parts. Part 1 involved conducting a survey to identify the extent of gambling problems, other addictions, and emotional distress amongst a sample of Asian adults enrolled in GP clinics in Auckland. In Part 2, early intervention resources were developed, promoted and delivered through general practices to facilitate Asian people's access to gambling harm minimisation interventions and other professional support services. A follow-up survey was conducted two to four months after the initial survey to assess changes in participants' levels of gambling risk and emotional wellbeing. The survey also asked if the participants had used any specialised interventions and support for their mental health issues and addictions. Evaluation of the research was undertaken to determine whether the aims of the research were being met, as well as to review the process of project delivery.

The original duration of the research was from August 2019 to September 2021. However, the COVID-19 pandemic and lockdown restrictions in 2000 had posed considerable challenges to the research. New Zealand (NZ) reported its first COVID-19 case on February 28, 2020. In March, the government introduced a four-level alert system. A country-wide level 4 lockdown was implemented between March 25 and April 27. This was followed by a slightly less restrictive level 3 lockdown until May 13. While lockdown restrictions were eased after May 2020, GP clinics had operated under considerable pressure amidst concerns about health professionals and patients contracting the virus through in-person clinical interactions. Physical distancing and health and safety measures were introduced. Due to the uncertainties created by the pandemic, the research project was put on hold in 2020.

Throughout 2020, the research team had closely monitored the rapidly changing COVID-19 situation. In consultation with the MOH, we explored how we could conduct the research safely during the pandemic, including adapting the survey delivery format from in-person to online, and using other methods of delivering intervention services such as videoconferencing, webinars and online resources, instead of face-to-face intervention services. The research project resumed in 2021 with the end date amended to November 30, 2021. The revised project timeline is presented in the Gantt-Chart below (Figure 1).

Figure 1 Revised project timeline

ACTIVITY	2019					2020	2021										
	Aug	Sept	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Preparation – design survey questionnaire; confirm collaboration for recruitment of Asian patients from GP clinics; submit ethics application																	
Initial survey – adapt survey to online; finalise participating GP clinics; launch the online survey; collect and analyse survey data						Research activities suspended due to the COVID-19 pandemic		LOCK-DOWN									
Intervention – design & produce a guided self-help resource; prepare & deliver *Maintaining Wellness Webinar Series;* collect feedback from webinar attendees																	
Follow-up survey – develop follow-up survey questions; launch the online follow-up survey; collect & analyse survey responses															COVID-19 LOCKDOWN		
Evaluation – measure if the aims of the research are met (outcome evaluation); assess whether the process of project delivery has worked (process evaluation)															COVID-19 LOCKDOWN		
Final report, resource development and dissemination of findings															COVID-19 LOCKDOWN		

Research activities in the first eight months of 2021 were on track, except the two lockdowns in February which had caused some delay in the launch of the initial survey. From August 2021, however, the COVID-19 Delta outbreak had plunged Auckland into an alert level 4 lockdown between August 17 and September 21, followed by a level 3 lockdown until December 2. This prolonged lockdown had greatly impacted on the follow-up survey implementation, and some of the evaluation activities. The number of participants/users in each research activity of the project is summarised in Table 1 below.

Table 1 Number of participants/users in each research activity

ACTIVITY	NUMBER OF PARTICIPANTS/USERS
Initial survey	
Provided completed responses	305
Provided contact details for follow-up survey	176
Intervention	
Guided self-help resource	Not recorded; the Resource was freely available online and at participating clinics
AFS Wellness Services	~200-250 per month; the Service was available at one participating clinic
Webinar 1	20
Webinar 2	22
Webinar 3	16
Follow-up survey	
Provided valid email addresses to receive the survey	165
Provided completed responses	20
Used specialised services	5

The next two sections detail the research design, activities, results and evaluation of the two parts of the research project. The final section discusses the implications of the research for policy and future provision and development of primary care-based interventions and support for Asian people.

2. GAMBLING PROBLEMS AMONG ASIAN PEOPLE IN PRIMARY CARE

In Part 1 of the research, a survey was conducted to identify the extent of gambling problems, other addictions, and emotional distress from a sample of Asian adults enrolled in two GP clinics in Auckland. Evaluation of this part of the research was to identify whether primary care can provide a setting for early identification of gambling problems for Asian people, as well as to review the process of survey delivery to identify the learnings for future improvements. This section outlines the survey design and presents the survey results. Following this, the methods used to conduct the evaluation and the evaluation findings are presented and discussed.

2.1 INITIAL SURVEY DESIGN AND METHODS

The aim of the initial survey was to explore the extent of gambling problems, other addictions, emotional distress, and help-seeking behaviour among a sample of Asian people aged 15 years and over who were enrolled in GP clinics in Auckland. Because Chinese, Indian, and Korean are the three largest ethnic subgroups within the Asian population in Auckland, GP clinics with high Chinese, Indian or Korean patient enrolment were the preferred research sites. The target was to collect 250 completed survey responses.

2.1.1 Participating clinics

Four GP clinics with high Asian patient enrolment located in north, central and south Auckland were invited to take part. Clinic A was the first clinic agreed to engage in the research. Located in north Auckland, the clinic is a one-stop medical centre with high Chinese and Korean patient enrolment. In 2016, AFS formed a partnership with this clinic when a counsellor from AFS was placed in the clinic once a week to provide counselling and support services to Asian patients who were referred by their GPs. In 2021, the service was expanded and renamed *Te Tumu Waiora,* or AFS Wellness Services (see section 3.1.3).

The CEO of Clinic A was first approached in October 2019 about the survey. She was very supportive and agreed to assist the recruitment of Asian patients enrolled in the clinic to take part in the survey. When the research restart in 2021 with the survey delivery format changed from in-person to online, the CEO reconfirmed her interest in participating in the survey.

Two GP clinics in central Auckland with high South Asian patient enrolment had also confirmed their participation in 2019. However, when we approached them again in March 2021, they informed us that they were no longer able to help us recruit patients from their clinics due to COVID-19 constraints. Subsequently, the research team sought assistance from a contact of AFS who worked in an Auckland-based primary health organisation (PHO). This PHO serves the largest South Asian population enrolled in GP clinics in New Zealand. Through this contact, we were introduced to the practice manager of Clinic B in south Auckland. This clinic has a growing South Asian patient enrolment because they have a dedicated doctor who speaks English and Tamil. Our project coordinator visited them in April 2021 and spoke to the practice manager, doctors, and nurses about our research. Collaboration with the clinic was established after the visit.

2.1.2 Survey questionnaire

A survey questionnaire was created. It consists of six sections:

Section A: General Information – gender, ethnic group, age group, country of birth, relationship status, residency status, employment status, highest educational qualification, English proficiency.

Section B: Psychological wellbeing – The Kessler Psychological Distress Scale (K10) was used as a brief screen to identify respondents' levels of distress at the time of survey. The K10 scale consists of 10 questions about emotional states, each with a five-level response scale (All the time=5, Most of the time=4, Some of the time=3, A little of the time=2, None of the time=1). Scores of the 10 items were summed to yield a minimum score of 10 and a maximum score of 50. Low scores indicate low levels of emotional distress and high scores indicate high levels of emotional distress. Respondents were also asked if they had sought help in the past 12 months to deal with their emotional distress, and their help-seeking sources (e.g. friend, family, GP, counsellor, alternative remedies, community, information from newspaper, TV, website and social media platforms).

Section C: Gambling in the household – The Problem Gambling Severity Index (PGSI) was used as a brief screen to identify respondents' levels of gambling risk over the past 12 months. The scale consists of 9 questions, each with a five-level response scale (Never=0, Rarely=1, Sometimes=1, Often=2, Always=3). Scores of the 9 items were summed to yield a minimum score of 0 and a maximum score of 27. Low scores indicate low levels of gambling risk and high scores indicate high levels of gambling harm. Respondents were also asked if other members in the household had gambled in the past 12 months, whether they had sought help to reduce or stop gambling and the help-seeking sources.

Section D: Alcohol use – In this section, respondents were asked if they had a drink containing alcohol in the past 12 months, how many drinks they had on a typical day when they were drinking, and how often they had six or more drinks on one occasion. Participants were also asked whether they had sought help to reduce or stop drinking in the past 12 months and the help-seeking sources.

Section E: Substance use – Respondents were asked how many cigarettes they smoked on an average day, whether they had sought help to stop smoking in the past 12 months, their help-seeking sources, whether they had ever used non-prescription drugs for recreational purposes, whether they had sought help to stop taking drugs in the past 12 months and the help-seeking sources.

Section F: Preferences towards using online services – This section was added to the survey to provide information about whether it was feasible and appropriate to deliver intervention services by webinars and other online resources. Questions included: (a) whether respondents had access to smartphone, broadband internet connection, tablet, laptop, personal computer; (b) what attracted them to use online services; (c) what hindered them from using online services; (d) their likelihood of using self-help resources, online coaching, peer support forum, webinars and online counselling; and (e) their preferences for social media platforms (e.g. Facebook, Instagram, WeChat, WhatsApp).

When the English version of the questionnaire was finalised (Appendix 1), it was translated into Chinese, Korean and Hindi (Appendices 2-4).

2.1.3 Online survey delivery platform

In changing the survey format from in-person to online, the research team had considered Survey Monkey, Red Cap and Qualtrics, and decided to use Qualtrics to conduct the online survey. Qualtrics was considered most appropriate because it would allow us to securely collect survey data and upload the survey in four different languages, including English, Chinese, Korean and Hindi.

The English version of the survey questionnaire was uploaded onto Qualtrics first. The layout of the questionnaire was reviewed to ensure that it was user friendly and that all the questions/items were clear when viewing the questionnaire on a smartphone, tablet, or computer. The branch logic of the questions was carefully laid out. This meant that if some respondents answered "never" or "no" to a certain question (e.g. "In the past 12 months, how often did you have a drink containing alcohol?"), they would not see any of the follow-up questions as they would not be relevant. When the survey

flow was finalised, the Chinese, Korean and Hindi translations were uploaded. Survey respondents had the opportunity to choose their language preference at any time while completing the questionnaire.

Finally, a pilot test was conducted to check for potential technological issues (e.g. download time and interface compatibility) and that all instructions were clear and adequate, ordering of the questions was appropriate, and that there were no errors in the Chinese, Korean and Hindi translations.

2.1.4 Survey distribution methods

Initially, the online survey was to be launched to Clinic A after Lunar New Year (around mid-February 2021). But with Auckland going into two lockdowns (February 14-17, and February 28 to March 7), the survey launch was deferred to March 1, 2021. A text message was sent by Clinic A to their Asian patients informing them of the survey. Eligible respondents were patients enrolled in Clinic A, belonged to any Asian ethnic group, aged 15 years or over and were able to provide informed consent. Those interested could use the survey link provided to take part.

Responses to the survey was low in the first week. After Auckland moved to alert level 2, posters and flyers were provided to Clinic A to distribute to patients coming into the clinic, and the survey was also advertised on their website. Clinic A also asked us to send them paper copies of the survey. They were distributed by clinic receptionists to Asian patients while they were waiting to see the doctor. Online survey numbers increased in the second week. By the third week, around 200 participants had completed the online survey, and about 10 paper copies were also collected.

The survey in Clinic A closed on April 30. A total of 434 recorded responses were collected. Of the 434 responses, 153 survey responses were incomplete and 281 were complete. Of the 281 complete responses, 260 were eligible. The 21 responses which were ineligible included eight who were not registered patients, seven did not belong to any Asian ethnic group and six under 15 years of age. The ineligible responses were removed from data analysis. Among the 260 participants who provided eligible responses, 149 provided their contact detail for follow-up contacts.

For Clinic B, the survey was launched on May 3, 2021. Unlike Clinic A which has an established system of communicating with patients using text messages, Clinic B did not have such a system and so only those patients who visited the clinic could see the poster and know about the survey. Interested patients could either scan a QR code that linked to the online survey or asked for a paper copy of the survey to complete. In order to increase survey responses, from week 3, Clinic B practice manager kindly helped to distribute paper survey questionnaires to patients of Asian backgrounds in the clinic and encouraged them to complete the survey while they were waiting to see the doctor. Following this, survey numbers started to pick up. The survey in Clinic B closed on June 30.

Sixty-two recorded responses were collected in Clinic B. Seventeen survey responses were ineligible, including four who were not registered with the clinic, and 13 with incomplete responses. The ineligible responses were removed from data analysis. Among the 45 who provided eligible responses, 27 (60%) provided their contact details for follow-up contacts. In total, 305 eligible survey responses were collected from the two clinics. This number has exceeded the target of 250 set for the research.

2.1.5 Data analysis

Survey data were entered into Excel spreadsheets and analysed using descriptive statistics, and descriptive comparisons of Asian ethnic group responses and gambling risk levels.

2.2 INITIAL SURVEY RESULTS

2.2.1 Survey participant characteristics

A total of 305 respondents completed the full survey: 260 (85.2%) from Clinic A and 45 (14.8%) from Clinic B. Forty-three percent were male, 56.7% female and 0.3% preferred not to say. The three largest

ethnic groups were Chinese (44.6%), Korean (37.7%) and Indian (10.5%). Other ethnicities included Cambodian, Filipino, Indonesian, Japanese, Malaysian and Sri Lankan (Table 2).

Table 2 Participant characteristics by Asian ethnic groups (N=305)

Participant characteristics	Chinese		Korean		Indian		Other		Total	
	N	%	N	%	N	%	N	%	N	%
Gender										
Male	59	*43.4*	56	*48.7*	8	*25.0*	8	*36.4*	131	*43.0*
Female	76	*55.9*	59	*51.3*	24	*75.0*	14	*63.6*	173	*56.7*
Prefer not to say	1	*0.7*	0	*0.0*	0	*0.0*	0	*0.0*	1	*0.3*
Total	136	*100.0*	115	*100.0*	32	*100.0*	22	*100.0*	305	*100.0*
Age group										
15-19 years	3	*2.2*	6	*5.2*	1	*3.1*	2	*9.1*	12	*3.9*
20-29 years	15	*11.0*	21	*18.3*	8	*25.0*	3	*13.6*	47	*15.4*
30-39 years	71	*52.2*	27	*23.5*	9	*28.1*	7	*31.8*	114	*37.4*
40-49 years	33	*24.3*	34	*29.6*	10	*31.3*	7	*31.8*	84	*27.5*
50-59 years	7	*5.1*	16	*13.9*	2	*6.3*	2	*9.1*	27	*8.9*
60-69 years	5	*3.7*	8	*7.0*	2	*6.3*	1	*4.5*	16	*5.2*
70-79 years	2	*1.5*	3	*2.6*	0	*0.0*	0	*0.0*	5	*1.6*
Total	136	*100.0*	115	*100.0*	32	*100.0*	22	*100.0*	305	*100.0*
Country of birth										
New Zealand	8	*5.9*	6	*5.2*	4	*12.5*	2	*9.1*	20	*6.6*
China	117	*86.0*	0	*0.0*	0	*0.0*	0	*0.0*	117	*38.4*
South Korea	0	*0.0*	107	*93.0*	0	*0.0*	0	*0.0*	107	*35.1*
India	0	*0.0*	0	*0.0*	14	*43.8*	0	*0.0*	14	*4.6*
Sri Lanka	0	*0.0*	0	*0.0*	0	*0.0*	6	*27.3*	6	*2.0*
Philippines	0	*0.0*	0	*0.0*	0	*0.0*	4	*18.2*	4	*1.3*
Hong Kong	2	*1.5*	0	*0.0*	0	*0.0*	1	*4.5*	3	*1.0*
Other	8	*5.9*	2	*1.7*	14	*43.8*	9	*40.9*	33	*10.8*
Not stated	1	*0.7*	0	*0.0*	0	*0.0*	0	*0.0*	1	*0.3*
Total	136	*100.0*	115	*100.0*	32	*100.0*	22	*100.0*	305	*100.0*
Year of arrival to New Zealand (for participants born overseas)										
Before 1980s	0	*0.0*	2	*1.8*	1	*3.6*	1	*5.0*	4	*1.4*
1980-1989	6	*4.7*	2	*1.8*	4	*14.3*	1	*5.0*	13	*4.6*
1990-1999	13	*10.2*	23	*21.1*	2	*7.1*	0	*0.0*	38	*13.3*
2000-2009	42	*32.8*	41	*37.6*	8	*28.6*	11	*55.0*	102	*35.8*
2010-2019	65	*50.8*	39	*35.8*	13	*46.4*	7	*35.0*	124	*43.5*
2020 and after	1	*0.8*	2	*1.8*	0	*0.0*	0	*0.0*	3	*1.1*
Not stated	1	*0.8*	0	*0.0*	0	*0.0*	0	*0.0*	1	*0.4*
Total	128	*100.0*	109	*100.0*	28	*100.0*	20	*100.0*	285	*100.0*
Relationship status										
Single	20	*14.7*	27	*23.5*	4	*12.5*	6	*27.3*	57	*18.7*
De facto relationship	7	*5.1*	6	*5.2*	1	*3.1*	2	*9.1*	16	*5.2*
Married	101	*74.3*	75	*65.2*	23	*71.9*	14	*63.6*	213	*69.8*
Separated	1	*0.7*	4	*3.5*	2	*6.3*	0	*0.0*	7	*2.3*
Divorced	5	*3.7*	2	*1.7*	2	*6.3*	0	*0.0*	9	*3.0*
Widowed	0	*0.0*	1	*0.9*	0	*0.0*	0	*0.0*	1	*0.3*
Not stated	2	*1.5*	0	*0.0*	0	*0.0*	0	*0.0*	2	*0.7*
Total	136	*100.0*	115	*100.0*	32	*100.0*	22	*100.0*	305	*100.0*

Participant characteristics	Chinese		Korean		Indian		Other		Total	
	N	%	N	%	N	%	N	%	N	%
Residence status										
NZ citizen	36	*26.5*	44	*38.3*	19	*59.4*	12	54.5	111	*36.4*
Permanent resident	88	*64.7*	55	*47.8*	7	*21.9*	8	36.4	158	*51.8*
Work visa holder	11	*8.1*	14	*12.2*	6	*18.8*	2	9.1	33	*10.8*
Student visa holder	0	*0.0*	2	*1.7*	0	*0.0*	0	0.0	2	*0.7*
Family sponsored migrant	1	*0.7*	0	*0.0*	0	*0.0*	0	0.0	1	*0.3*
Total	136	*100.0*	115	*100.0*	32	*100.0*	22	100.0	305	*100.0*
Employment status										
Full-time employment	71	52.2	50	*43.5*	20	*62.5*	11	*50.0*	152	*49.8*
Part-time, temporary or casual employment	17	12.5	19	*16.5*	3	*9.4*	3	*13.6*	42	*13.8*
Self-employed	16	11.8	16	*13.9*	2	*6.3*	1	*4.5*	35	*11.5*
Not in paid employment	23	16.9	22	*19.1*	2	*6.3*	3	*13.6*	50	*16.4*
Other	9	6.6	8	*7.0*	5	*15.6*	4	*18.2*	26	*8.5*
Total	136	100.0	115	*100.0*	32	*100.0*	22	*100.0*	305	*100.0*
Highest educational achievement or qualifications										
No formal school qualification	0	*0.0*	0	*0.0*	3	*9.4*	0	*0.0*	3	*1.0*
NZ secondary school qualification	5	*3.7*	9	*7.8*	2	*6.3*	4	*18.2*	20	*6.6*
Overseas secondary school qualification	3	*2.2*	7	*6.1*	2	*6.3*	6	*27.3*	18	*5.9*
Certificate or Diploma	25	*18.4*	10	*8.7*	9	*28.1*	4	*18.2*	48	*15.7*
Bachelor's Degree	68	*50.0*	61	*53.0*	10	*31.3*	4	*18.2*	143	*46.9*
Postgraduate/Master's/ Doctorate Degree	34	*25.0*	23	*20.0*	5	*15.6*	3	*13.6*	65	*21.3*
Other	1	*0.7*	4	*3.5*	1	*3.1*	1	*4.5*	7	*2.3*
Not stated	0	*0.0*	1	*0.9*	0	*0.0*	0	*0.0*	1	*0.3*
Total	136	*100.0*	115	*100.0*	32	*100.0*	22	*100.0*	305	*100.0*
English proficiency										
Do not speak English	0	*0.0*	3	*2.6*	0	*0.0*	0	*0.0*	3	*1.0*
Speak English poorly	29	*21.3*	41	*35.7*	1	*3.1*	0	*0.0*	71	*23.3*
Speak enough English to express health needs	70	*51.5*	35	*30.4*	2	*6.3*	8	*36.4*	115	*37.7*
Speak English very well	37	*27.2*	36	*31.3*	29	*90.6*	14	*63.6*	116	*38.0*
Total	136	*100.0*	115	*100.0*	32	*100.0*	22	*100.0*	305	*100.0*

Across the three main ethnic groups, a majority of Chinese (87.5%) and Indian (84.4%) respondents were between 20-49 years of age. A majority (85.5%) of Korean respondents were between 20-59 years of age.

A majority (93.1%) of survey respondents were born overseas. Only 6.6% were born in New Zealand (NZ). Of those born overseas, 83.6% of Chinese 75% of Indian respondents arrived to NZ between 2000-2019. The majority (94.5%) of Korean respondents arrived to NZ between 1990-2019.

The majority (88.2%) of survey respondents were NZ citizens or permanent residents. 18.8% of Indian respondents were work visa holders; the corresponding percentages for Korean and Chinese respondents were 12.2% and 8.1% respectively.

A majority (75%) of survey respondents were married or in a de facto relationship. About a quarter (23.5%) of Korean respondents were single, compared to 14.7% of Chinese and 12.5% of Indian respondents who were single.

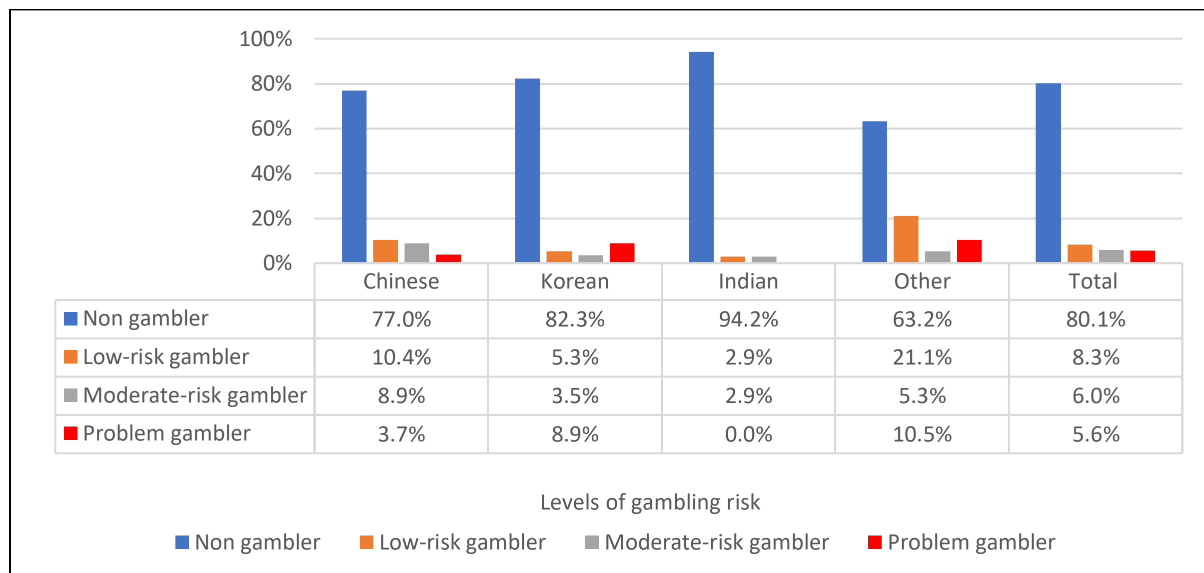
Almost 50% were in full-time employment. Across the three main ethnic groups, Indian respondents had the highest percentages in full-time employment (62.5%) and the lowest percentages (6.3%) not in paid employment. For Chinese, just over half (52.2%) were in full-time employment and 16.9% not in paid employment; the corresponding percentages for Koreans were 43.5% and 19.1% respectively.

The majority of Chinese (75%) and Korean (73%) respondents had at least a Bachelor's degree; the corresponding percentages for Indian were 46.9%. However, only 51.5% of Chinese and 30.4% of Korean respondents said they spoke enough English to express their health needs. Among Indian respondents, 90.6% reported that they spoke English very well (Table 2).

2.2.2 Levels of gambling risk by Asian ethnic groups

Four respondents had missed one or several items of the *Problem Gambling Severity Index (PGSI).* These responses were removed before scorings were made. Of the 301 respondents who completed the full PGSI scale, 80.1% were non-gamblers (PGSI 0), 8.3% low-risk gamblers (PGSI 1-2), 6% moderate-risk gamblers (PGSI 3-7) and 5.6% problem gamblers (PGSI ≥8). Across ethnic groups, Indian had the highest percentage of non-gamblers (94.2%), Chinese had the highest percentages of moderate-risk gamblers (8.9%) and Other ethnic groups had the highest percentages of problem gamblers (10.5%) and low-risk gamblers (21.1%) (Figure 2).

Figure 2 Levels of gambling risk by Asian ethnic groups (N=301)



	Chinese	Korean	Indian	Other	Total
Non gambler	77.0%	82.3%	94.2%	63.2%	80.1%
Low-risk gambler	10.4%	5.3%	2.9%	21.1%	8.3%
Moderate-risk gambler	8.9%	3.5%	2.9%	5.3%	6.0%
Problem gambler	3.7%	8.9%	0.0%	10.5%	5.6%

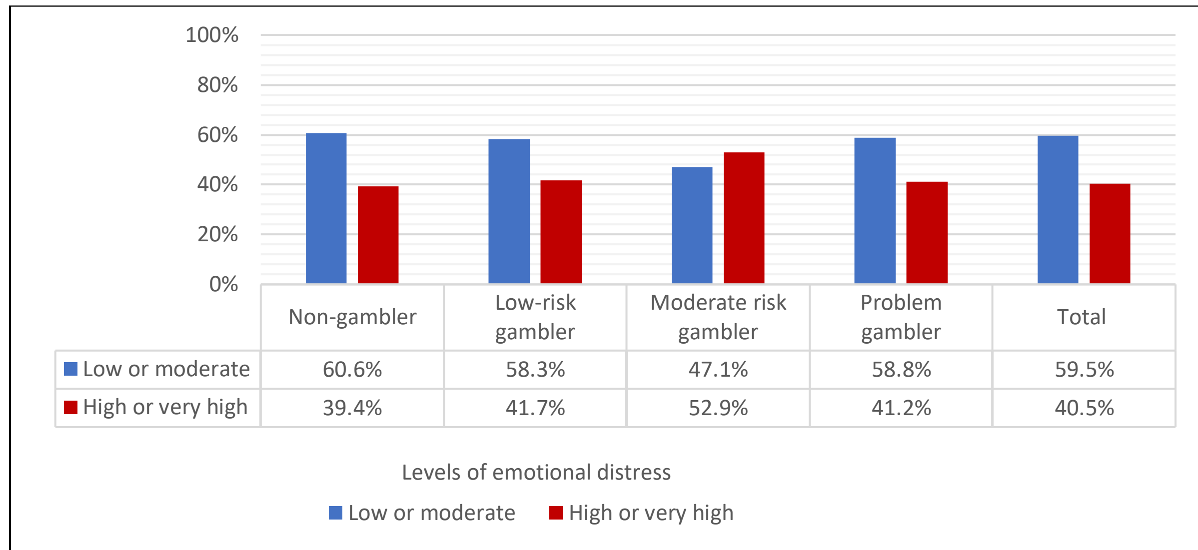
The survey also asked if there were other members in the household who had gambled in the past 12 months. Of the 305 respondents who answered the question, most (84.9%) answered "none at all". 8.2% reported that their family members gambled "a little", 2.6% said their family members gambled "a moderate amount of time", and none said their family members gambled "a lot".

2.2.3 Co-existing issues

Seven respondents had missed one or more items of the *Kessler Psychological Distress Scale* (K10). These responses were removed before scorings were made. Based on the 298 respondents who completed the full K10 scale, their levels of emotional distress ranged from low (K10 10-15, 26.5%), moderate (K10 16-21, 32.6%), high (K10 22-29, 26.5%) to very high (K10 30-50, 14.4%). Across ethnic

groups, Indian had the highest percentages with very high emotional distress (21.9%). The corresponding percentages for Chinese and Korean were 13.4% and 12.5% respectively. Respondents' emotional distress levels by gambling risk levels were also examined. Moderate-risk gamblers had the highest percentages (52.9%) with high or very high levels of emotional distress[1] (Figure 3).

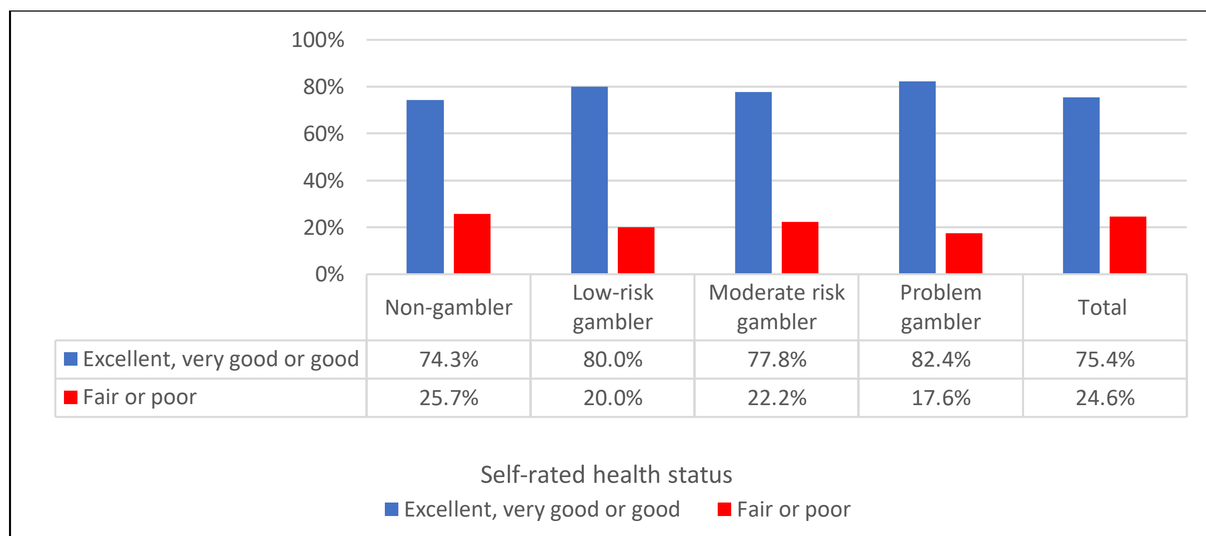
Figure 3 Levels of emotional distress by gambling risk levels (N=294)



	Non-gambler	Low-risk gambler	Moderate risk gambler	Problem gambler	Total
Low or moderate	60.6%	58.3%	47.1%	58.8%	59.5%
High or very high	39.4%	41.7%	52.9%	41.2%	40.5%

Regarding other co-existing issues, the survey results show that the majority of respondents reported that their health were excellent, very good or good (Figure 4), did not drink or did not have six or more drinks on one occasion in the past 12 months (Figure 5), did not smoke or smoked less than one cigarette on an average day (Figure 6), and had not used non-prescription drugs for recreational purposes in the past 12 months (Figure 7). Across gambling risk levels, the percentages of problem gamblers and moderate-risk gamblers who had six or more drinks on one occasion (35.3% and 27.8%) were higher than those of low-risk gamblers and non-gamblers (16% and 22.4%) (Figure 5). The percentages of smokers among problem gamblers (23.5%) and moderate-risk gamblers (11.1%) were also higher than those of low-risk gamblers (4%) and non-gamblers (4.6%) (Figure 6).

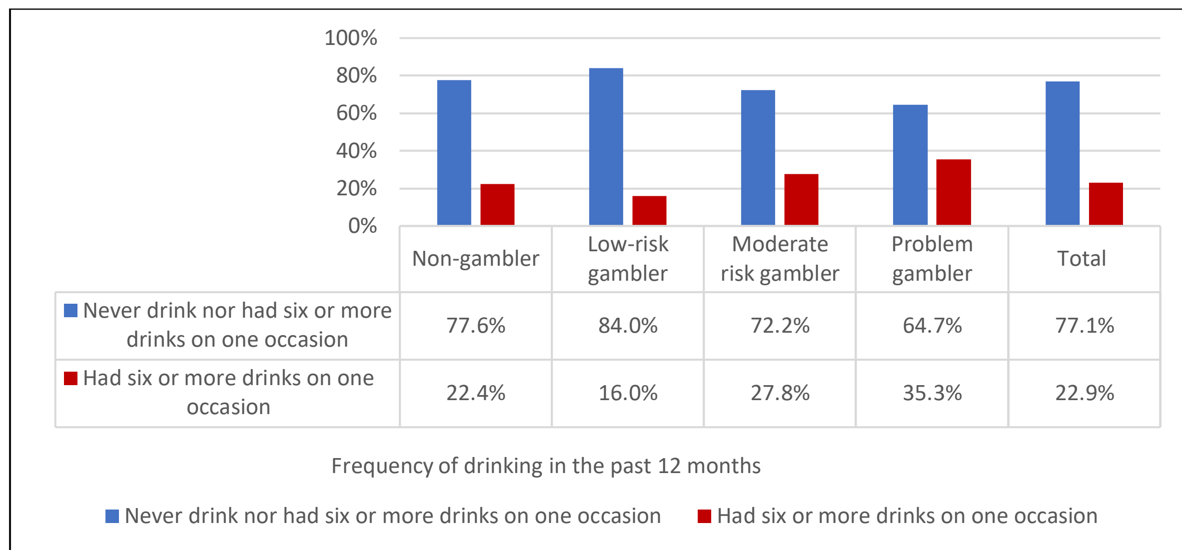
Figure 4 Gambling risk levels by self-rated health status (N=301)



	Non-gambler	Low-risk gambler	Moderate risk gambler	Problem gambler	Total
Excellent, very good or good	74.3%	80.0%	77.8%	82.4%	75.4%
Fair or poor	25.7%	20.0%	22.2%	17.6%	24.6%

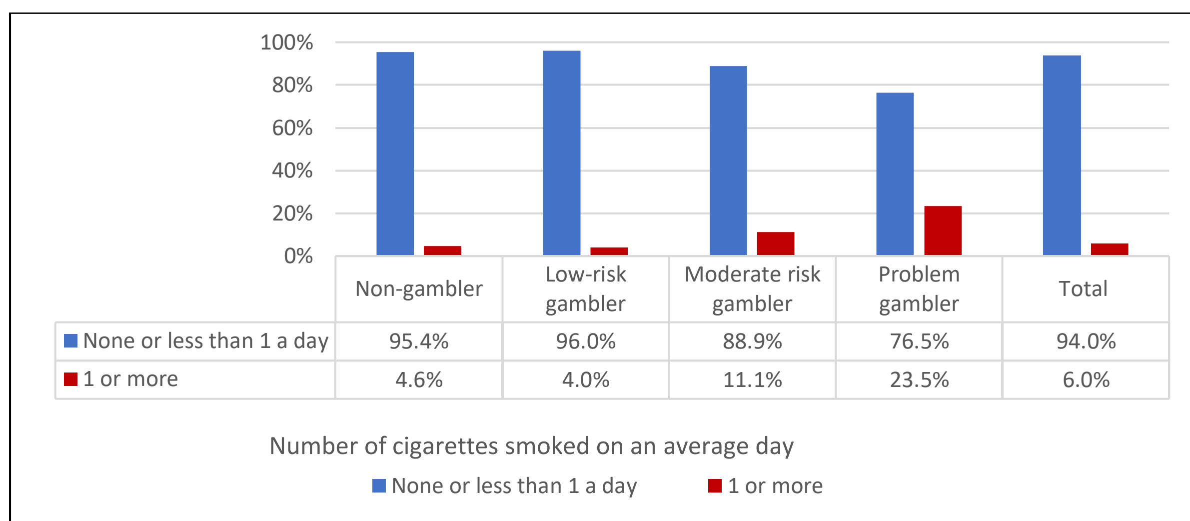
[1] Levels of emotional distress are combined into 'low or moderate' and 'high or very high' categories because some levels have very small number of responses.

Figure 5 Gambling risk levels by frequency of drinking six or more drinks on one occasion in the past 12 months (N=301)



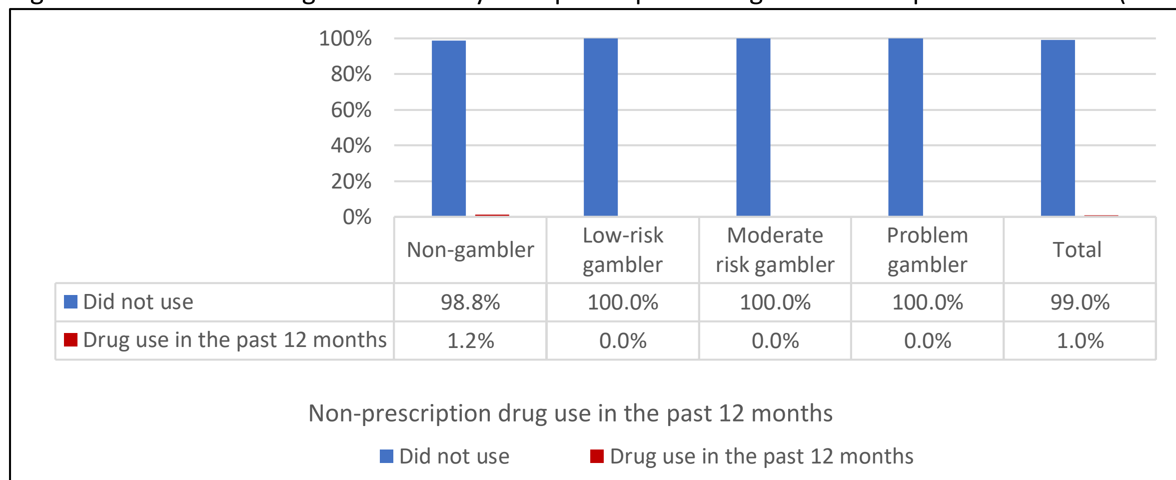
	Non-gambler	Low-risk gambler	Moderate risk gambler	Problem gambler	Total
Never drink nor had six or more drinks on one occasion	77.6%	84.0%	72.2%	64.7%	77.1%
Had six or more drinks on one occasion	22.4%	16.0%	27.8%	35.3%	22.9%

Figure 6 Gambling risk levels by number of cigarettes smoked on an average day (N=301)



	Non-gambler	Low-risk gambler	Moderate risk gambler	Problem gambler	Total
None or less than 1 a day	95.4%	96.0%	88.9%	76.5%	94.0%
1 or more	4.6%	4.0%	11.1%	23.5%	6.0%

Figure 7 Gambling risk levels by non-prescription drug use in the past 12 months (N=301)



	Non-gambler	Low-risk gambler	Moderate risk gambler	Problem gambler	Total
Did not use	98.8%	100.0%	100.0%	100.0%	99.0%
Drug use in the past 12 months	1.2%	0.0%	0.0%	0.0%	1.0%

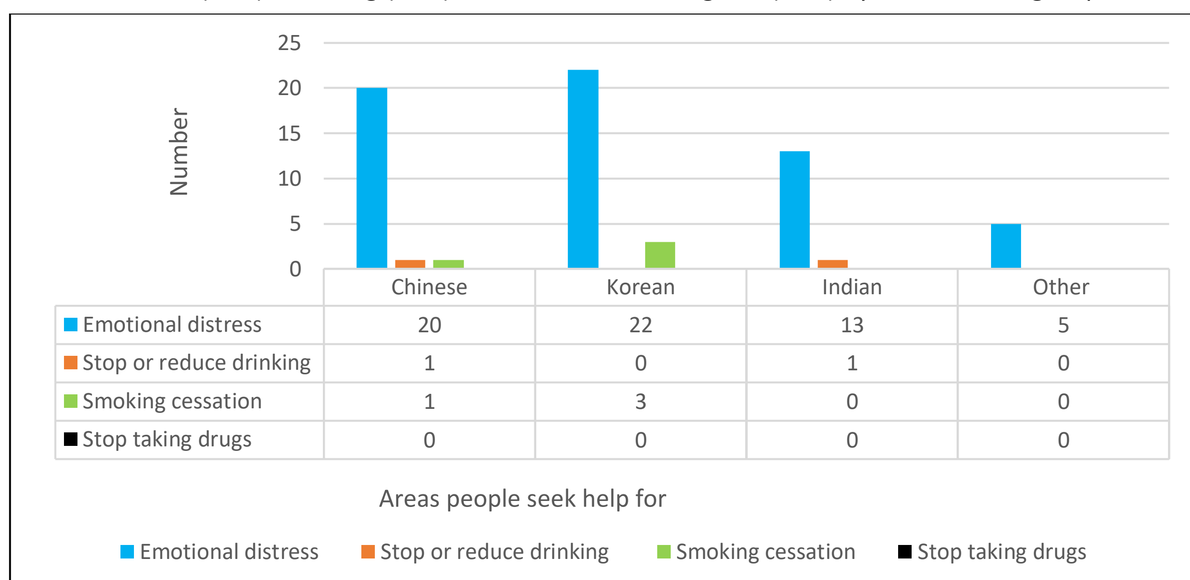
2.2.4 Help-seeking behaviour and help-seeking sources

Although one in five Asian respondents in the survey reported low-risk, moderate-risk or problem gambling, and 2.6% reported their family members gambled a moderate amount, only two respondents had sought help in the past 12 months to reduce or stop gambling (Figure 8). Help seeking to reduce or stop drinking or smoking was also low, with two and four respondents respectively who had sought help in these areas in the past 12 months. No survey respondents reported that they had sought help to stop taking drugs in the past 12 months. In comparison, more respondents had sought help for emotional distress (Figure 9). Among the respondents who had sought help for emotional distress, those with higher emotional distress were more prepared to seek help than those with lower levels of distress. (Figure 10).

Figure 8 Number of respondents who had sought help for gambling issues by gambling risk levels and Asian ethnic groups (N=2)

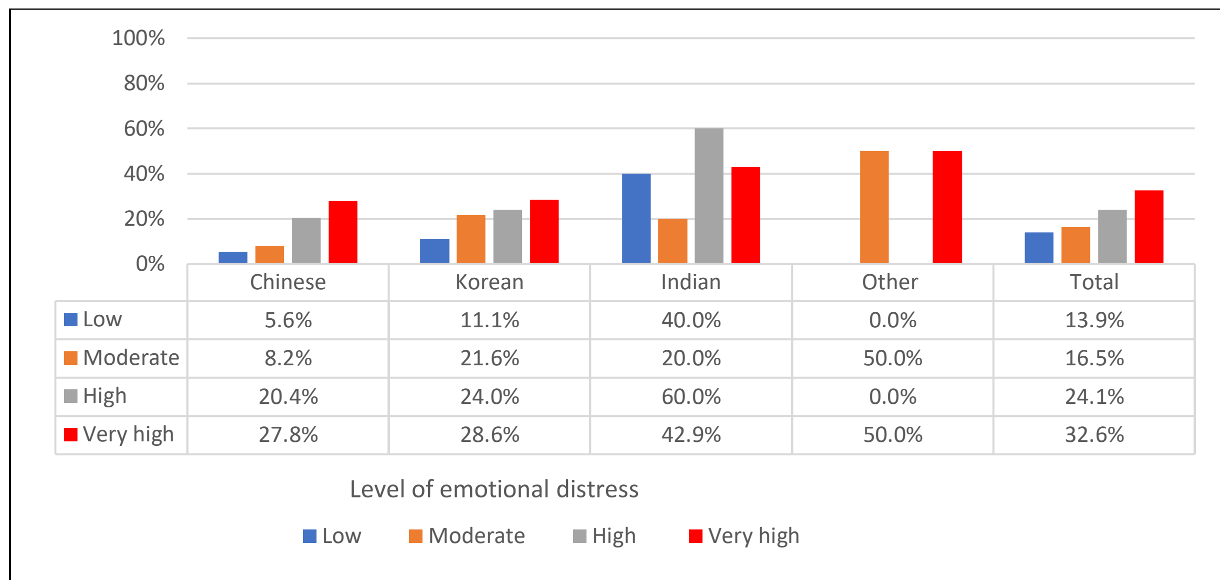
	Chinese	Korean	Indian	Other
Non-gambler	0	0	1	0
Low-risk gambler	0	1	0	0
Moderate-risk gambler	0	0	0	0
Problem gambler	0	0	0	0

Figure 9 Number of respondents who had sought help for emotional distress (N=60), drinking (N=2), smoking (N=4) and recreational drug use (N=0) by Asian ethnic groups



	Chinese	Korean	Indian	Other
Emotional distress	20	22	13	5
Stop or reduce drinking	1	0	1	0
Smoking cessation	1	3	0	0
Stop taking drugs	0	0	0	0

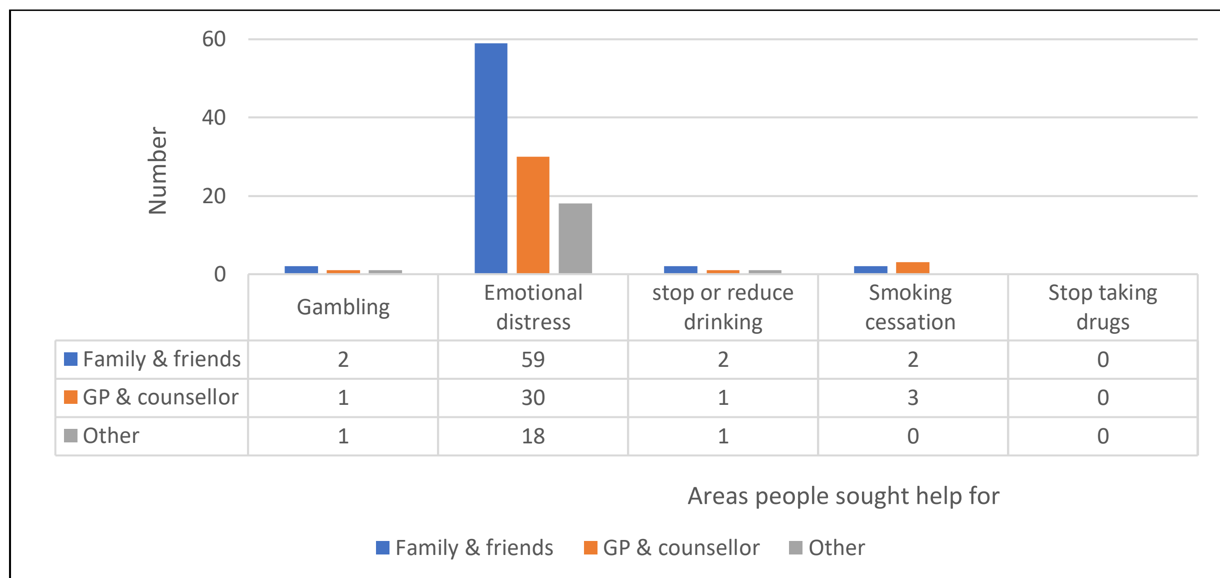
Figure 10 Percentages of participants who had sought help by levels of emotional distress and Asian ethnic groups (N=301)



	Chinese	Korean	Indian	Other	Total
Low	5.6%	11.1%	40.0%	0.0%	13.9%
Moderate	8.2%	21.6%	20.0%	50.0%	16.5%
High	20.4%	24.0%	60.0%	0.0%	24.1%
Very high	27.8%	28.6%	42.9%	50.0%	32.6%

Regarding help-seeking sources, those who had sought help most commonly sought help informally from family and/or friends; only half had sought help formally from GPs or counsellors. Other sources of help included alternative remedies, community groups and social platforms (Figure 11).

Figure 11 Help seeking sources by areas people seek help for*



	Gambling	Emotional distress	stop or reduce drinking	Smoking cessation	Stop taking drugs
Family & friends	2	59	2	2	0
GP & counsellor	1	30	1	3	0
Other	1	18	1	0	0

*Number of participants who had sought help for gambling (N=2); Emotional distress (N=60); Drinking (N=2); Smoking (N=4); Recreational drug use (N=0)

2.2.5 Likelihood of using online services

Survey results on respondents' access to digital devices showed that the majority had access to smartphones (84.9%), Wi-Fi (83.6%), laptops with a camera (54.4%), tablets (43.6%) and/or personal computer with a camera (23.3%). Two (1%) had none of the above (Table 3).

Table 3 Access to digital devices* by Asian ethnic groups (N=305)

	Chinese		Korean		Indian		Other		Total	
	N	%	N	%	N	%	N	%	N	%
Smartphone	112	*82.4*	101	*87.8*	26	*81.3*	20	*90.9*	259	*84.9*
Wifi	120	*88.2*	87	*75.7*	28	*87.5*	20	*90.9*	255	*83.6*
Tablet	75	*55.1*	39	*33.9*	12	*37.5*	7	*31.8*	133	*43.6*
Laptop with a camera	82	*60.3*	54	*47.0*	17	*53.1*	13	*59.1*	166	*54.4*
Personal computer with camera	36	*26.5*	22	*19.1*	5	*15.8*	8	*36.4*	71	*23.3*
None of the above	0	*0.0*	1	*0.9*	1	*3.1*	0	*0.0*	2	*0.7*
Other	0	*0.0*	0	*0.0*	1	*3.1*	0	*0.0*	1	*0.3*
Total	136	*100*	115	*100*	32	*100*	22	*100*	305	*199*

*Participants could √ multiple answers, so total percentages could be greater than 100

Regarding incentives for using online services, the top three reasons were: “convenience / can do it in your own time” (84.3%), “Flexible / easy to schedule” (63%) and “no travel involved to seek support” (56.4%). Other reasons included: “can get support in the privacy of your own space” (52.1%), “can get timely support” (46.9%), “more cost effective” (40.3%), “receive support in a comfortable environment” (20.7%) and “feel less embarrassed (e.g. less likely other people will find out about online services use)” (18.4%) (Table 4).

Table 4 Incentives for using online services* (N=305)

	Chinese		Korean		Indian		Other		Total	
	N	%	N	%	N	%	N	%	N	%
Convenience	115	*84.6*	102	*88.7*	21	*65.6*	19	*86.4*	257	*84.3*
Can get timely support	74	*54.4*	48	*41.7*	10	*31.3*	11	*50.0*	143	*46.9*
Can get support in the privacy of your own space	67	*49.3*	66	*57.4*	9	*28.1*	17	*77.3*	159	*52.1*
No travel involved to seek support	86	*63.2*	65	*56.5*	8	*25.0*	13	*59.1*	172	*56.4*
Most cost effective	58	*42.6*	41	*35.7*	9	*28.1*	15	*68.2*	123	*40.3*
Flexible	102	*75.0*	65	*56.5*	10	*31.3*	15	*68.2*	192	*63.0*
Feel less embarrassed	28	*20.6*	19	*16.5*	5	*15.6*	4	*18.2*	56	*18.4*
Receive support in a comfortable environment	23	*16.9*	37	*32.2*	0	*0.0*	3	*13.6*	63	*20.7*
None of the above	1	*0.7*	0	*0.0*	1	*3.1*	0	*0.0*	2	*0.7*
Other	2	*1.5*	3	*2.6*	8	*25.0*	0	*0.0*	13	*4.3*
Total	136	*100*	115	*100*	32	*100*	22	*100*	305	*100*

*Participants could √ multiple answers, so total percentages could be greater than 100.

For barriers to using online services, the top three barriers were: “prefer face-to-face interactions” (22%), “poor internet connection” (17.4%) and “limited access to the internet” (6.9%), Other barriers included: “concerned about other people finding out use of online services” (5.2%), “cannot find time to use online services” (4.9%), “cannot find a private place to use online services” (3.3%), “limited access to smartphone/tablet/laptop/PC” (2.6%) and “do not know how to use smartphone/tablet/laptop/PC” (2.6%). Over half of (56.4%) survey respondents did not identify any barriers to using online services (Table 5).

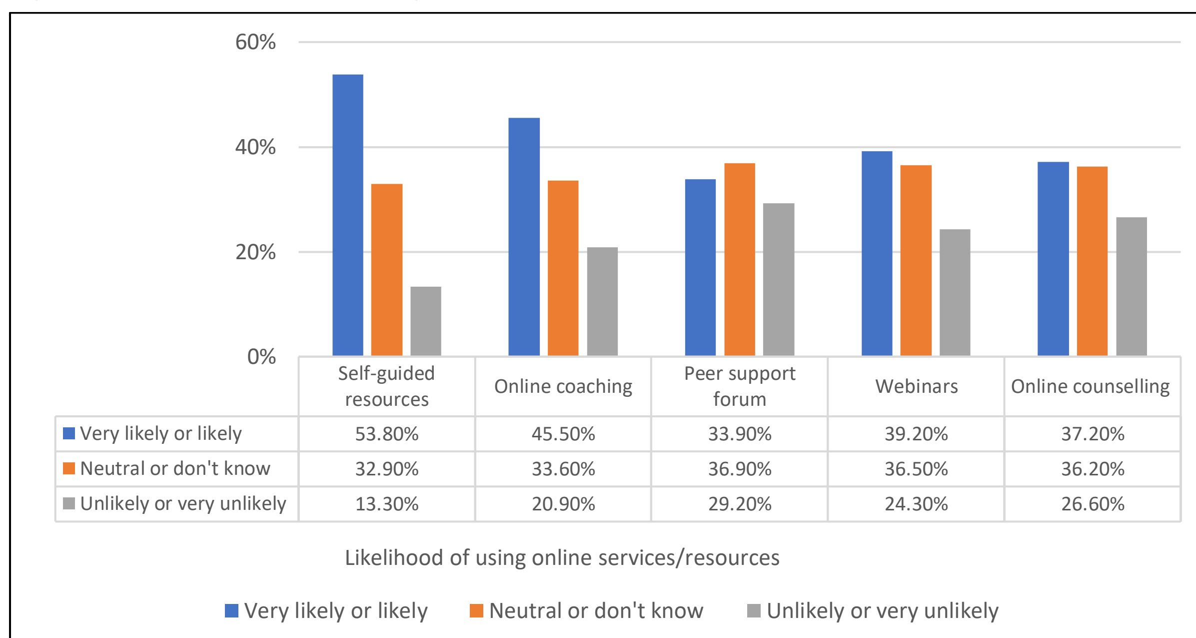
Table 5 Barriers to using online services* (N=305)

	Chinese		Korean		Indian		Other		Total	
	N	%	N	%	N	%	N	%	N	%
Limited access to the internet	9	*6.6*	6	*5.2*	6	*18.8*	0	*0.0*	21	*6.9*
Poor internet connection	35	*25.7*	14	*12.2*	2	*6.3*	2	*9.1*	53	*17.4*
Limited access to smartphone/tablet/laptop/PC	3	*2.2*	1	*0.9*	4	*12.5*	0	*0.0*	8	*2.6*
Do not know how to use smartphone/tablet/laptop/PC	1	*0.7*	6	*5.2*	1	*3.1*	0	*0.0*	8	*2.6*
No people to help with using smartphone/tablet/laptop/PC	1	*0.7*	2	*1.7*	0	*0.0*	0	*0.0*	3	*1.0*
Cannot find a private place to use online services	5	*3.7*	3	*2.6*	0	*0.0*	2	*9.1*	10	*3.3*
Cannot find time to use online services	9	*6.6*	5	*4.3*	1	*3.1*	0	*0.0*	15	*4.9*
Prefer face-t-face interactions	38	*27.9*	23	*20.0*	3	*9.4*	3	*13.6*	67	*22.0*
Concerned about other people finding out use of online services	6	*4.4*	8	*7.0*	2	*6.3*	0	*0.0*	16	*5.2*
Other	2	*1.5*	1	*0.9*	0	*0.0*	1	*4.5*	4	*1.3*
Did not identify any barrier	64	*47.1*	67	*58.3*	24	*75.0*	17	*77.3*	172	*56.4*
Total	136	*100*	115	*100*	32	*100*	22	*100*	305	*100*

*Participants could √ multiple answers, so total percentages could be greater than 100.

When respondents were asked about their likelihood of using online services, 53.8% were likely or very likely to use self-guided resources (information, tools and guidelines that can be used personally for improving and managing wellbeing), 45.5% were likely or very likely to use online coaching (personalised online support and coaching developed by a health professional), 39.2% likely or very likely to use webinars (free online health education seminars presented by health professionals), 37.2% likely or very likely to use online counselling (one-on-one counselling services conducted via video conference such as Zoom or Skype), and 33.9% likely or very likely to use peer-support forum (online support groups to share and discuss health experiences). However, about one third were neutral or did not know if they would use any online services (Figure 12).

Figure 12 Likelihood of using online services



2.3 EVALUATION AIMS AND METHODS

The aims of evaluation of this part of the research were to identify whether primary care (mainly general practices) can provide a setting for early identification of gambling problems for Asian people (outcome evaluation), as well as to review the process of survey implementation to identify the areas that had worked, the challenges encountered, and the areas that needed improvements (process evaluation). Table 6 outlines the activities that were undertaken to conduct this evaluation.

Table 6 Part 1 evaluation activities

Type of evaluation	Evaluation aims	Evaluation activities	Analysis of evaluation information
Outcome evaluation	To identify whether primary care can provide a setting for early identification of gambling problems for Asian people	Obtain outcome data on the rates of problem gamblers (PGSI ≥8), moderate-risk gamblers (PGSI 3-7) and low-risk gamblers (PGSI 1-2) among the survey sample in general practices	Compare the rates of gambling problems from the survey with other national studies. The hypothesis is that the rates of problem gamblers, moderate-risk gamblers and low-risk gamblers as measured by PGSI obtained from the survey conducted in GP clinics would be higher than the rates obtained from the Health & Lifestyle Survey and the NZ National Gambling Study.
Process evaluation	To review the process of survey implementation to identify the areas that had worked, the challenges encountered, and the areas that needed improvements	1. Discussions with project team to monitor survey progress weekly, as well as to identify project team's perceptions about the survey delivery process and engagement with GP clinics	Analyse process data to answer the following questions: • Was the survey implemented as planned? What were the challenges? • What was the engagement process with GP clinics? • What areas had worked? What improvement may be made?
		2. Obtain feedback from clinic staff to identify their perceptions of survey implementation and challenges	Analyse clinic feedback on the following questions: • What were the benefits of the survey to GP clinics? • What were the challenges in recruiting patients to take part in the survey? • Any other suggestions for the improvement of survey delivery process in GP clinics?

2.4 EVALUATION RESULTS

2.4.1 Comparisons of rates of gambling problems from this survey with results from national gambling studies

The primary aim of evaluation was to identify whether primary care can provide a setting for early identification of gambling problems for Asian people. Harmful gambling is often under-reported by Asian people due to fear of stigma and embarrassment; however the familiar and trustful setting of general practices can help to reduce Asian people's fear of stigma and facilitate them to disclose their gambling behaviour. We hypothesised that the rates of problem gamblers, moderate-risk gamblers

and low-risk gamblers as measured by PGSI obtained from the survey conducted in GP clinics would be higher than the rates obtained from national gambling studies such as the Health & Lifestyle Survey and the NZ National Gambling Study.

Based on the PGSI, of the 301 survey respondents from GP clinics who completed the full scale, 80.1% were non-gamblers or non-problem gamblers (PGSI 0), 8.3% low-risk gamblers (PGSI 1-2), 6% moderate-risk gamblers (PGSI 3-7) and 5.6% problem gamblers (PGSI ≥8). Comparisons of these results with those from two national gambling studies are presented in Table 7 below.

Table 7 Levels of gambling risk among Asian adults in current survey in GP clinics: Comparisons with the Health and Lifestyle Survey* and the NZ National Gambling Study**

	Non gamblers (%)	Non-problem gamblers (%)	Low-risk gamblers (%)	Moderate-risk gamblers (%)	Problem gamblers (%)	Sample size (n)
Survey in GP clinics (2021)	80.1		8.3	6	5.6	301
Health & Lifestyle Survey (HLS) 2014	46	47	3.3	2.0	1.3	225
HLS 2016	47	47	3.2	2.8	0	325
NZ National Gambling Study (NGS) Wave 1 (2012)	39.8	51.6	5.8	2.2	0.7	798
NGS Wave 2 (2013)	43.9	49.4	5.1	1.3	0.4	403
NGS Wave 3 (2014)	41.9	51.5	5.2	1.4	0.1	322
NGS Wave 4 (2015)	40.8	53.5	4.5	1.2		282

* Thimasarn-Anwar et al., 2017
** Abbott, Bellringer & Garrett, 2018

In the NZ Nation Gambling Study (2012 -2015) and the Health and Lifestyle Survey (2014 and 2016), the rates of problem gambling among Asian adults ranged from 0% to 1.3%, moderate-risk gambling from 1.3% to 2.8%, and low-risk gambling from 3.2% to 5.8% (Table 7). In comparison, our survey conducted in general practices had detected much higher rates of problem gamblers (5.6%), moderate-risk gamblers (6%) and low-risk gamblers (8.3%). Overall, one in five (19.9%) survey participants from general practices reported problems with gambling across a spectrum of severity (low, moderate or problem) in the past 12 months, 10% to 14% higher than the results from the National Gambling Study and the Health and Lifestyle Survey. These results support the notion that primary care can provide an important setting for early identification of gambling risk among Asian adults. Further discussion of the evaluation findings will be made in Section 2.5.

2.4.2 Analysis of process data collected during survey implementation

Process data were collected from research team members during team meetings and weekly communication with clinic staff to monitor the progress of the survey. Analysis of process data provided early feedback as to whether or not the survey was proceeding as intended, what barriers were encountered, and what changes were needed. The process evaluation answered the following questions:

- *Was the survey implemented as planned? What were the main challenges?*

Our biggest challenges were the COVID-19 pandemic and lockdown restrictions, which had caused considerable disruption to survey implementation and some adaptations had been made. Nonetheless, a total of 305 completed survey responses were received from the two participating clinics. The number had exceeded the target of 250 set for this research. The profiles of survey

respondents were diverse. They were from different Asian ethnic groups, age groups, birthplaces, residence status, employment status, educational background and English language proficiency.

- *What was the engagement process with GP clinics?*

Our long-established relationship with Clinic A had enabled a seamless engagement process. Their General Manager, Practice Administrator, receptionists and staff had provided great support for our survey, including displaying posters and flyers about the survey in the clinic, sending text messages about the survey to patients of Asian backgrounds, promoting the survey on their website and distributing the paper survey to patients while they were waiting to see the doctor. Clinic B is smaller in size and has less staff than Clinic A. Although this was our first time working together, our engagement with Clinic B was a positive and smooth process.

- *What areas had worked? What improvement may be made?*

Our collaboration with the two GP clinics had worked well. We believe the relationships we have built with both clinics will be an ongoing collaboration. We are keen to continue our engagement with them for future initiatives/programmes to support Asian communities.

In response to the COVID-19 pandemic and lockdown restrictions, the research team had adapted the survey delivery from face-to-face to online. We had also created a multilingual survey which enabled respondents to choose one of four languages (English, Chinese, Korean and Hindi) to take part. A reminder to complete the survey were sent before the survey closed. We believe all these strategies had helped to increase the survey response rates. However, we are mindful that some subgroups may be difficult to reach or involve in online survey, such as older people, those who are digitally illiterate, those who do not have online accessible devices and those who are socially isolated. For these subgroups, face-to-face survey is likely to get better responses.

2.4.3 Analysis of feedback from clinic staff

The two clinics were asked to provide feedback on survey implementation. Initially we would like to have a face-to-face meeting with them, or organise a Zoom session to talk through the questions. However, as Auckland was in lockdown from August 18, both clinics had chosen to answer the questions by email.

- *What were the benefits of the survey to GP clinic?*

Both clinics reported that being involved in the survey made them realise the need to discuss mental health and addiction issues with the Asian community. The survey picked up on problems that affect patients but which they normally do not feel comfortable talking about. The provision of resources in major Asian languages was also found to be very helpful, particularly because the resources are developed to address the particular concerns of the people surveyed.

- *What were the challenges in recruiting patients to take part in the survey?*

The clinics did not identify any challenges in recruiting patients. One clinic suggested that in future, the text messages to invite patients to take part in the survey would be better sent in small batches to small subgroups, i.e. teenage boys, teenage girls, older men, older women, with each invite worded for the age group and gender. It was hoped that this could further increase the response rate.

- *Other suggestions or comments*

One clinic noted that the number of survey respondents who had sought help from health providers was quite low. They were interested to know why people seek help or not and what they can do to make health care and services more accessible. They also wanted to know how people enrolled in the clinic experience their service and whether Asian people trust their service. Both clinics were interested in further collaboration with AFS.

2.5 DISCUSSION

The evaluation findings from Part 1 research indicate that the rates of gambling problems (including low-risk, moderate-risk and problem gambling) found among Asian adults in the survey conducted in general practices were 10% to 14% higher than the results from the 2012-2015 National Gambling Study and the 2014 and 2016 Health and Lifestyle Survey. Stigma is a key barrier preventing Asian people from disclosing their problematic gambling to others and seeking help (Sobrun-Maharaj et al., 2012; Wong & Tse, 2003). In both the National Gambling Study and the Health and Lifestyle Survey, interviews were conducted face-to-face with participants in their homes, whereas our survey respondents completed the survey anonymously. The stigmatisation of problem gambling can act as a barrier for Asian people to disclosing their problematic gambling to interviewers in face-to-face interviews. Having a gambling problem is commonly perceived as shameful and largely an individual's own fault, with blame mainly attributed to a person's own failings, including their bad character, having an addictive personality, or a lack of self-control (Carroll, Rodgers, Davidson & Sims, 2013; Horch & Hodgins, 2013). For these reasons, individuals tend to keep their gambling problem hidden to protect themselves from being shunned by society and significant others (Au & Ho, 2015; Hing, Russell, Nuske & Gainsbury, 2015; Hing et al., 2016).

In our survey conducted in general practices, participants completed the survey privately and anonymously, which could have helped to reduce their concerns about stigma and discrimination. Besides, survey participants were recruited from the general practice where they were enrolled in. Participants' positive relationship with, and trust in, the practice and their family doctor could make them more likely to answer the survey questions truthfully, but they might be reluctant to disclose their problems when the questions were asked from a stranger. These findings support the notion that primary care can provide a setting for early identification of gambling risk among Asian adults.

Our survey findings also identified co-existing emotional distress, hazardous drinking and smoking among Asian respondents with moderate-risk or problem gambling. However, help-seeking for harmful gambling and other addiction issues among Asian respondents was very low. These results suggest that there is a strong need to support Asian people to seek help and early interventions for harmful gambling and associated mental health issues, alongside psychoeducation and support services for affected others in the family. The next part of this research will explore if primary care has the potential to provide a setting for facilitating Asian people's access to interventions.

3. PRIMARY CARE-BASED INTERVENTIONS AND FOLLOW-UP SURVEY

In Part 2 of the research, early intervention resources/services were developed, promoted and delivered through general practices to facilitate Asian people's access to interventions for harmful gambling and related mental health issues. A follow-up survey was delivered to 165 participants who had provided valid contact details in the initial survey, to find out if they had used any of the interventions provided, and to assess if there had been any change in their levels of gambling risk and emotional wellbeing since the initial survey. Evaluation of this part of the research was to identify whether primary care can provide a setting for improving Asian people's access to interventions. This section presents the research approaches and results.

3.1 DEVELOPMENT OF EARLY INTERVENTION RESOURCES

The development of early intervention resources in this research aligned with the 'stepped care' model which involves delivering prevention and promotion services at the primary care level, 'stepping up' to secondary/specialist services as clinically required (Mental Health Commission, 2012). As New Zealand's only gambling harm minimisation Asian service provider, AFS has been delivering, since 1999, secondary/specialist gambling harm minimisation services under a Ministry of Health contract, which include the Asian Helpline [2] (secondary prevention) and counselling services (intensive/clinical treatment). But there are limited prevention services that Asian people can access at the primary care level. Hence, the following early intervention resources were developed and delivered through the participating GP clinics.

3.1.1 A guided self-help resource

Due to the stigma of problem gambling, self-help may be the first form of help that people use. As harmful gambling is to some extent associated with hazardous drinking, tobacco smoking and substance use, and people who are addicted to these issues are also likely to suffer from emotional distress, *A guide for Asian people to manage addictions and emotional distress* was developed as part of the research project to provide guided self-help to people who may be experiencing co-existing problems. This guided self-help resource aimed to help Asian people to: (a) identify whether they may be experiencing difficulties in managing issues associated with gambling, smoking, alcohol, drugs and emotional distress; (b) learn some strategies to manage these issues; and (c) obtain information about available professional support services. The resource was developed by AFS gambling counsellors, and peer reviewed by external clinicians (including psychiatrist, clinical psychologist and counsellor) in the relevant field. It is available in four languages: English, Chinese, Korean and Hindi.

The four versions of the resource were launched in May 2021. Printed copies of the resource were made available in the two GP clinics (see Appendix 5 for an English version of the resource). Electronic versions of the resource are freely available on AFS website:
https://www.asianfamilyservices.nz/resources/resource-categories/asian-family-services-resources/

3.1.2 Maintaining Wellness Webinar Series

[2] A national telephone service operated by AFS in eight languages (English, Cantonese, Hindi, Japanese, Korean, Mandarin, Thai and Vietnamese). The Asian Helpline provides a primary point of contact for services for many Asian people who need assistance in a range of issues, from gambling harm to settlement and related housing, financial, parenting and/or intergenerational issues. Callers can remain anonymous when they speak to a trained counsellor in their preferred language over the phone. Counsellors provide telephone counselling, support services, telephone follow-up, and referrals to face-to-face services as appropriate.

An online webinar series on health and wellness, family psychoeducation and preventing and minimising gambling harm were developed to replace the face-to-face public talks and psychoeducation workshops which were originally planned for. This change was made because the COVID-19 pandemic has created a new health and safety risk for face-to-face public talks and workshops that we need to manage. Online webinars were used to maintain social distancing and to limit the spread of COVID-19. Participants could get information and support in the privacy of their own space, and remain anonymous to other attendees for all webinars.

The webinars were developed and presented by AFS qualified counsellors. Webinar 1 on Health and Wellness aimed at raising awareness of the impact of stress on wellbeing and providing some tips to manage stress and anxiety. Webinar 2 on family psychoeducation aimed at raising awareness of the harm associated with gambling and how gambling can affect others in the family. Webinar 3 on preventing and minimising gambling harm aimed at raising awareness of the warning signs of problem gambling and motivating those who are at risk to get help earlier. All webinars introduced the professional support services offered by AFS to address a spectrum of severity of gambling harm and co-existing problems, including the Asian Helpline, counselling services and AFS Wellness Services.

Each live webinar lasted for 60 minutes. Presenters used PowerPoint slides to draw out and explain the key messages from the webinars to the target audience. In-webinar polls were used to get attendees to answer questions and keep them enaged. Attendees could also send text chat messages during the webinars to ask or answer questions. The webinars were delivered free of charge in Mandarin, Korean and English between June and August 2021. The webinar series were advertised on AFS website, social media platforms and ethnic networks. Survey participants from the two GP clinics who had provided their contact details were informed of the webinars and how to access them (Appendices 6-8). In total there were 20 attendees for webinar 1 (13 Chinese, 4 Korean and 3 English), 22 for webinar 2 (11 Chinese, 10 Korean and 1 English) and 16 for webinar 3 (7 Chinese, 7 Korean and 2 English). After the webinars were delivered, they were uploaded to AFS website and YouTube channels:
https://www.asianfamilyservices.nz/events/workshops/maintaining-wellness-webinar-series-1-chinese/
https://www.asianfamilyservices.nz/events/workshops/maintaining-wellness-webinar-series-2-korean/
https://www.asianfamilyservices.nz/events/workshops/maintaining-wellness-webinar-series-3-english/

3.1.3 AFS Wellness Services

AFS Wellness Services are provided in Clinic A since 2021 under a Comprehensive Care PHO contract. Five health improvement practitioners (HIPs) and health coaches (HCs) from AFS are based in Clinic A. HIPs are registered practitioners such as psychologists, nurses, occupational therapists and social workers who provide health interventions and cultural support to patients for issues related to mental health and addictions (Te Pou, n.d.). HCs are from diverse backgrounds and cultures. They are trained to help patients understand health issues, provide emotional support for lifestyle changes and facilitate patients' access to appropriate resources to support their health management. For further information, go to: https://asianfamilyservices.nz/services/afs-wellness-services-at-apollo-medical-centre/

Patients enrolled in Clinic A can be referred by their GPs to see the health improvement practitioners and health coaches based in the clinic (Feng & Wang, 2021). Around 200 to 250 patients used the AFS Wellness Services each month.

3.2 FOLLOW-UP SURVEY DESIGN AND METHODS

A follow-up survey was conducted with survey respondents from Clinics A and B who had given their contact details in the initial survey. The main purposes were to: (a) examine any changes in respondents' gambling participation and emotional health since the initial survey, and (b) explore whether the respondents had used any resources and services that AFS provided to help Asian people deal with gambling, other addictions and mental health issues, and their satisfaction with any specialised services that they had used.

3.2.1 Follow-up survey design and questionnaire

The follow-up survey questionnaire consisted of 10 questions. The first section asked about respondents' self-assessed health status, levels of gambling risk (using *Problem Gambling Severity Index*, PGSI) and emotional distress (using *Kessler Psychological Distress Scale*, K10), and if they felt that their health, gambling participation and emotional state had stayed the same, got better or worse since the initial survey. The second section asked if the respondents had used the following specialised services/resources in the past three months: guided self-help resource, Maintaining Wellness Webinar Series, AFS Wellness Services[3], Asian Helpline and counselling services. They were asked to rate their satisfaction with any service(s) that they had used. The survey took about 10 minutes to complete.

The questions were first created in English, and then translated into Chinese and Korean. The Hindi translation had not been prepared for the follow-up survey, because no respondent had used the Hindi version of the questionnaire in the initial survey. After that, all three versions of the questionnaire (English, Chinese and Korean) were uploaded onto Survey Monkey. We used Survey Monkey for the follow-up survey because our Qualtrics license had expired.

3.2.2 Follow-up survey distribution methods

The follow-up survey was launched on August 12, 2021. A total of 149 respondents from Clinic A and 27 respondents from Clinic B who gave their contact details in the initial survey were sent a text or email message about the follow-up survey and a link to the survey. The message was written in English, Chinese, or Korean; respondents were sent messages in the same language that they had completed the initial survey. Eleven emails were unable to be delivered due to invalid or fake email addresses.

Five days after the follow-up survey was launched, the COVID-19 Delta outbreak had plunged Auckland into an alert level 4 lockdown between August 17 and September 21, followed by a level 3 lockdown until December 3. The lockdown had greatly impacted on the survey implementation. Of the 165 emails or text messages which were successfully sent, Survey Monkey analytics showed that 127 people (77%) opened the survey link, and nine completed survey responses were submitted within the first four days. However, after Auckland moved to alert level 4 lockdown on August 17, no further survey responses were received. On August 21 after a reminder email/text message was sent, 10 more survey responses were received. A final reminder email was sent on September 1 but only one more survey response was received. Due to the prolonged lockdown and the uncertainty about when the restrictions in Auckland could be eased, the survey was ended on September 10.

In total, when the follow-up survey closed on September 10, twenty completed survey responses (12.1%) were received; 107 people (64.8%) had started the survey before the lockdown but did not complete it. 38 (23%) did not open the survey link.

3.2.3 Data analysis method

The follow-up survey involved connecting the data previously provided by the same respondents in the initial survey with the data they provided in their follow-up survey. An ID code was assigned to

[3] This service is offered in Clinic A only. Survey respondents from Clinic B were not given this item.

both surveys and a contact list was created to send the follow-up survey link to respondents' email addresses or phone numbers. This allowed us to track the respondents' data from both surveys anonymously. Then, respondents' ratings of their health status, their PGSI scores and their K10 scores in both surveys were analysed to examine any changes. Respondents' use of specialised services to deal with their gambling, other addictions and mental health issues were also analysed.

3.3 FOLLOW-UP SURVEY RESULTS

- *Follow-up survey participant characteristics*

A total of 20 respondents completed the follow-up survey: eight (40%) were male and twelve (60%) were female. A majority (75%) were aged between 30 and 49 years. The largest ethnic groups were Korean (60%) and Chinese (35%). One respondent was Japanese. In the initial survey, respondents' ethnicities were more diverse, including Indian, Sri Lankan, Filipino, Indonesian and Malaysian. These groups were not represented in the follow-up survey (Table 8).

Table 8 Participant characteristics: Follow-up survey (N=20) cf. Initial survey (N=305)

	Follow-up survey		**Initial survey**	
	Number	*Percent*	Number	*Percent*
Gender				
Male	8	*40.0*	131	*43.0*
Female	12	*60.0*	173	*56.7*
Prefer not to say	0	*0.0*	1	*0.3*
Total	**20**	***100***	**305**	***100***
Ethnic group				
Chinese	7	*35.0*	135	*44.3*
Korean	12	*60.0*	115	*37.7*
Indian	0	*0.0*	34	*11.2*
Japanese	1	*5.0*	2	*0.7*
Other	0	*0.0*	18	*5.9*
Not stated	0	*0,0*	1	*0.3*
Total	**20**	***100***	**305**	***100***
Age group				
15-29	1	*5.0*	59	*19.3*
30-39	9	*45.0*	114	*37.4*
40-49	6	*30.0*	84	*27.5*
50-59	1	*5.0*	27	*8.9*
60 and over	3	*15.0*	21	*6.9*
Total	**20**	***100***	**305**	***100***
Country of birth				
New Zealand	0	*0.0*	20	*6.6*
China	7	*35.0*	117	*38.4*
South Korea	11	*55.0*	107	*35.1*
India	0	*0.0*	14	*4.6*
Japan	1	*5.0*	2	*0.7*
Other	1	*5.0*	41	*13.4*
Not stated	0	*0.0*	4	*1.3*
Total	**20**	***100***	**305**	***100***

	Follow-up survey		Initial survey	
	Number	*Percent*	Number	*Percent*
Year of arrival to NZ (for participants born overseas)				
Before 1989	1	*5.0*	17	*6.0*
1990 – 1999	4	*20.0*	38	*13.4*
2000 – 2009	7	*35.0*	102	*35.9*
2010 = 2019	8	*40.0*	124	*43.7*
2020 and after	0	*0.0*	3	*1.1*
Total	**20**	***100***	**284**	***100***
Marital status				
Single	1	*5.0*	57	*18.7*
Married / De fecto	17	*85.0*	229	*75.1*
Separated / Divorced	1	*5.0*	16	*5.2*
Widowed	1	*5.0*	1	*0.3*
Not stated	0	*0.0*	2	*0.7*
Total	**20**	***100***	**305**	***100***
Citizenship and migrant status				
NZ citizen	4	*20.0*	111	*36.4*
Permanent resident	16	*80.0*	158	*51.8*
Work / Study visa holder	0	*0.0*	35	*11.5*
Other	0	*0.0*	1	*0.3*
Total	**20**	***100***	**305**	***100***
Employment status				
Full-time employment	10	*50.0*	152	*49.8*
Part-time, temporary or casual employment	2	*10.0*	41	*13.4*
Self-employment	1	*5.0*	39	*12.8*
Not in paid employment	7	*35.0*	54	*17.7*
Other	0	*0.0*	19	*6.2*
Total	**20**	***100***	**305**	***100***
Highest educational achievement				
No formal school qualification	0	*0.0*	3	*1.0*
Secondary school qualification	2	*10.0*	38	*12.5*
Certificate or Diploma	2	*10.0*	48	*15.7*
Bachelor's degree	10	*50.0*	143	*46.9*
Postgraduate/Masters/doctoral degree	6	*30.0*	65	*21.3*
Other	0	*0.0*	7	*2.3*
Not stated	0	*0.0*	1	*0.3*
Total	**20**	***100***	**305**	***100***
English proficiency				
Do not speak English	2	*10.0*	3	*1.0*
English – poorly	6	*30.0*	71	*23.3*
English – enough to express health needs	8	*40.0*	115	*37.7*
English – very well	4	*20.0*	116	*38.0*
Total	**20**	***100***	**305**	***100***

All of the follow-up survey respondents were born overseas: 75% arrived to New Zealand between 2000 and 2019, and 25% arrived before 2000. They were either permanent residents (80%) or New Zealand citizens (20%). A majority (85%) were married. In terms of employment status, 50% were full-time employed, 10% had part-time, temporary or casual employment and 5% was self-employed. One-third (35%) were not in paid employment.

A majority of follow-up survey respondents had either Bachelor's degrees (50%), or post-graduate/Master's/ doctoral degrees (30%). Regarding their English proficiency, one in five (20%)

stated that they spoke English very well, 40% spoke enough English to express their health needs, 30% said they spoke English poorly, and 10% did not speak English (Table 8).

- *Levels of gambling risk, emotional distress and self-rated health status in the two surveys*

Three follow-up respondents did not complete the Problem Gambling Severity Index (PGSI). Of the 17 who completed the full scale, 15 (88.2%) were non-gamblers, and 2 (11.8%) low-risk gamblers. The corresponding numbers (and percentages) in the initial survey were 16 (94.1%) and 1 (5.9%) respectively (Figure 13). All respondents felt that their involvement in gambling activities had stayed mostly the same since the initial survey (Tables 9).

Figure 13 Follow-up survey respondents' levels of gambling risks in the two surveys

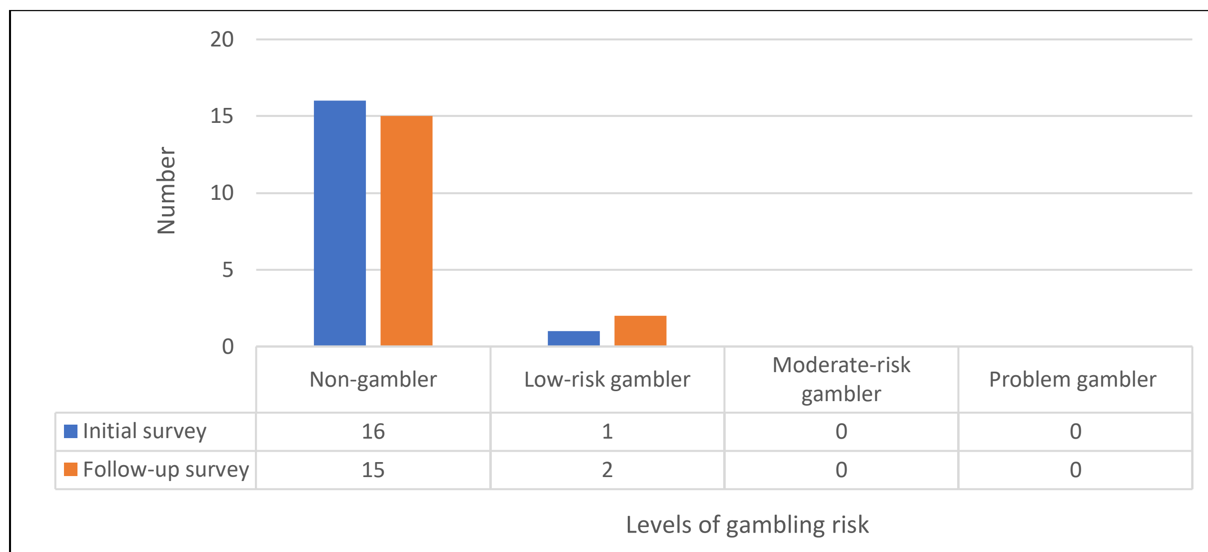


Table 9 Follow-up survey respondents' self-assessed change in their involvement in gambling activities since the initial survey (N=17)

	A lot better	A little better	Stayed mostly the same	A little worse	A lot worse	Total
Number	0	0	17	0	0	**17**
Percent	*0.0*	*0.0*	*100*	*0.0*	*0.0*	***100***

One survey respondent did not complete the Kessler Psychological Distress Scale (K10). Of the 19 who completed the full scale, four (21.1%) had low level of psychological distress, 11 (57.9%) medium, three (15.8%) high and 1 (5.3%) very high levels of distress. Corresponding numbers (and percentages) in the initial survey were 4 (21.1%), 9 (47.4%), 5 (26.3%), and 1 (5.3%) respectively (Figure 14). Overall, twelve survey respondents (63.2%) felt that their overall emotional states since the initial survey had stayed mostly the same, six (31.6%) reported that their emotional states had gone better and one (5.3%) felt they had gone a little worse (Table 10).

Figure 14 Follow-up survey respondents' levels of emotional distress in the two surveys

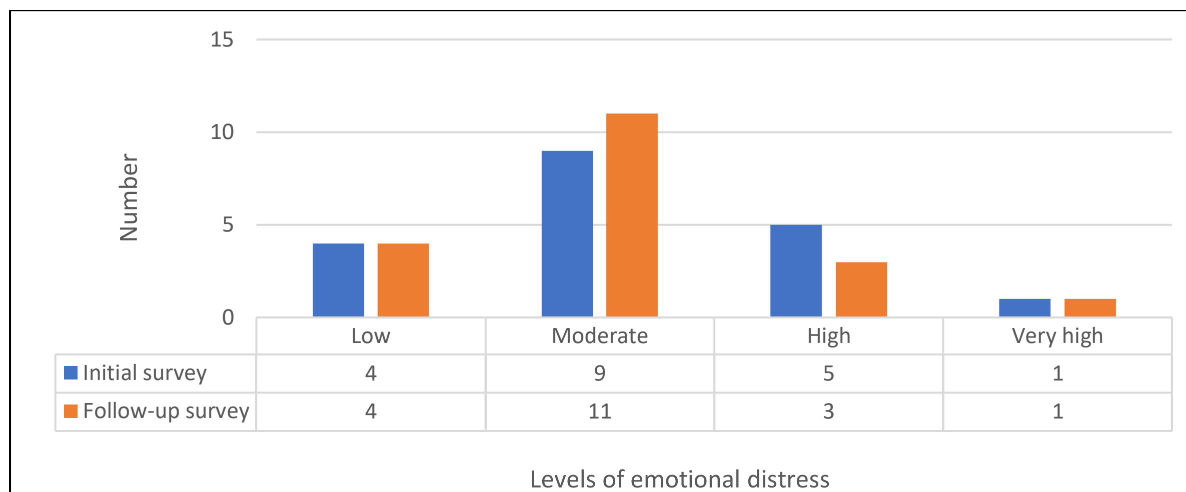


Table 10 Follow-up survey respondents' self-assessed change in their overall emotional states since the initial survey

	A lot better	A little better	Stayed mostly the same	A little worse	A lot worse	Total
Number	1	5	12	1	0	**19**
Percent	*5.3*	*26.3*	*63.2*	*5.3*	*0.0*	***100***

A majority of survey respondents rated their health status as good (8, 40%), very good (5, 25%) or excellent (4, 20%) in the follow-up survey. One (5%) rated their health as fair and two (10%) poor (Figure 15). Eighteen respondents (90%) felt their health had stayed mostly the same since the initial survey, and two (10%) felt better. None reported that their health had gone worse (Table 11).

Figure 15 Follow-up survey respondents' self-rated health status in the two surveys

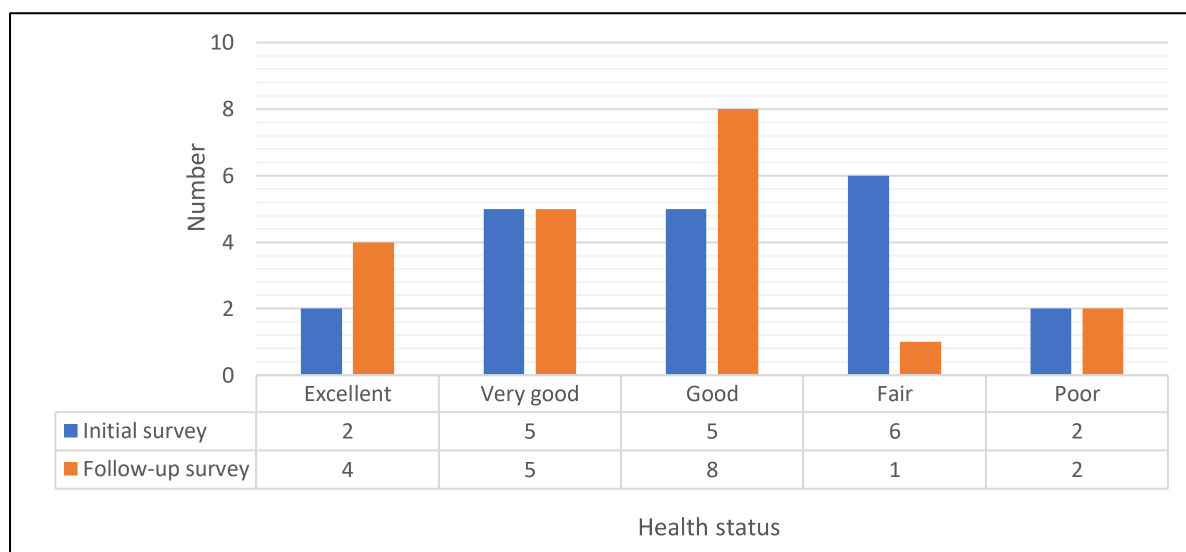


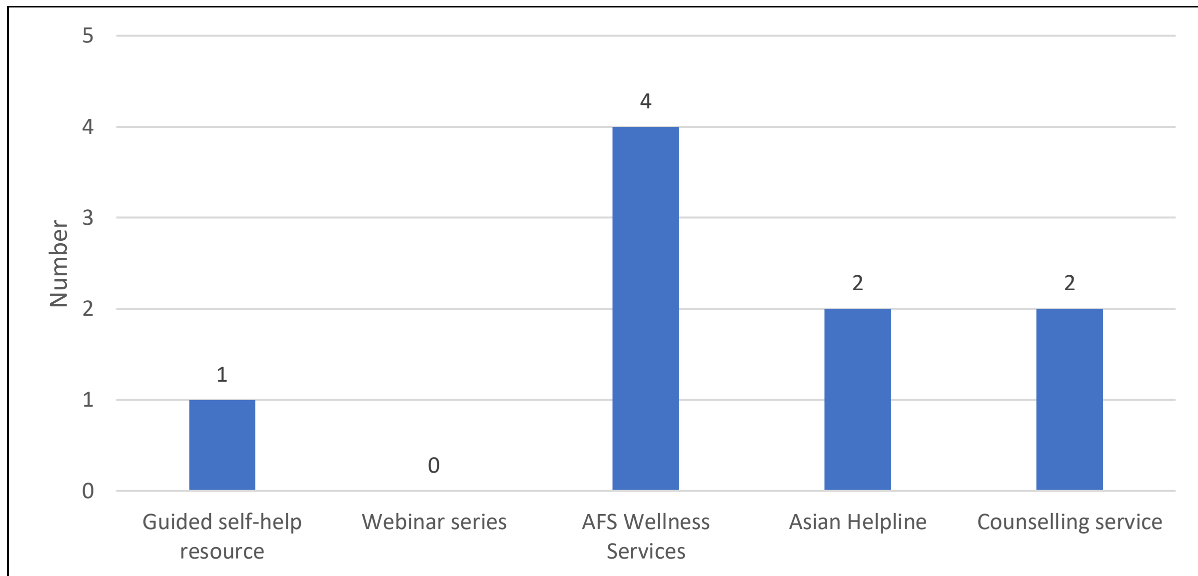
Table 11 Follow-up survey respondents' self-assessed change in their health status since the initial survey

	A lot better	A little better	Stayed mostly the same	A little worse	A lot worse	Total
Number	1	1	18	0	0	**20**
Percent	*5.0*	*5.0*	*90.0*	*0.0*	*0.0*	***100***

- *Use of specialised services and satisfaction levels*

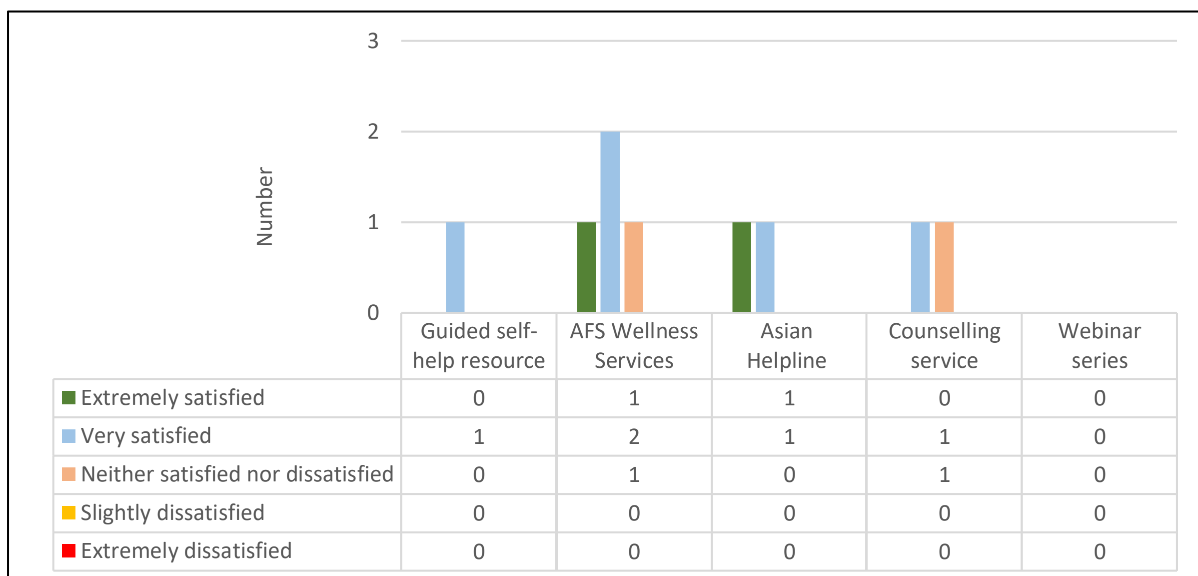
One in four respondents in the follow-up survey reported that they had used specialised services provided by AFS. The services that they had used included: AFS Wellness Services (4), Asian Helpline (2), counselling services (2) and guided self-help resource (1). None of the survey respondents had attended the online webinars (Figure 16).

Figure 16 Types of specialised services used by follow-up survey respondents



Among the respondents who had used services, most were highly satisfied with the services that they had used. Two of the four respondents who had used the Wellness Services rated their satisfaction level as very satisfied; for the other two respondents, one was extremely satisfied and one neither satisfied nor dissatisfied. Of the two respondents who had used the Asian Helpline, one was extremely satisfied and the other one was very satisfied with the service. The one respondent who had used the guided self-help resource was also very satisfied. Of the two participants who had used counselling services, one was very satisfied and the other one was neither satisfied nor dissatisfied (Figure 17).

Figure 17 Satisfaction level of follow-up survey respondents who had used specialised services



	Guided self-help resource	AFS Wellness Services	Asian Helpline	Counselling service	Webinar series
Extremely satisfied	0	1	1	0	0
Very satisfied	1	2	1	1	0
Neither satisfied nor dissatisfied	0	1	0	1	0
Slightly dissatisfied	0	0	0	0	0
Extremely dissatisfied	0	0	0	0	0

3.4 EVALUATION AIMS AND METHODS

The primary aim of the evaluation of Part 2 research was to identify whether general practices can provide a setting for facilitating Asian people's access to interventions. Due to the COVID-19 outbreak, the need for online intervention has grown, but this format of service delivery is still new to Asian communities. In this project, online webinars were developed to replace traditional face-to-face public talks and seminars, aiming at helping attendees to gain knowledge and understanding concerning harmful gambling, and to learn skills for stress management and self-care. Hence, another aim of evaluation was to identify if the intended outcomes of the webinar series were achieved, and to review the webinar content and implementation for future improvements. Table 12 below outlines the activities that were undertaken to conduct this evaluation.

Table 12 Part 2 evaluation activities

Type of evaluation	Evaluation aims	Evaluation activities	Analysis of evaluation information
Outcome evaluation	To measure webinar attendees' behaviours, attitudes and knowledge concerning harmful gambling after attending the seminars	Collect webinar attendees' responses to live polling questions delivered at each webinar. Attendees responded to each question by rating their answers on a 10-point scale.	Analyse attendees' webinar poll responses to gauge if the following target outcomes (measured by average scores of at least 6 out of 10) were achieved: • at least moderate understanding of the impacts of harmful gambling • at least moderate awareness of the warning signs of harmful gambling • at least some increase in knowledge on how to prevent and minimise gambling harm and where to get professional help • the skills for managing stress and self-care introduced in the seminars were at least somewhat helpful
Process evaluation	To review the webinar content and implementation for future improvements	Obtain feedback from webinar presenters	Qualitative analysis of webinar presenters' feedback on their experience of webinar delivery, and their suggestions for future improvements of webinar content
Outcome evaluation	To identify whether general practices can provide a setting for facilitating Asian people's access to interventions for problematic gambling	Conduct follow-up survey to obtain data on participants who had used specialised services, including their PGSI categories and their PGSI scores in their initial and follow-up surveys	Due to the Delta outbreak in Auckland in 2021, survey participation was low; recruitment across PGSI categories was not achieved Conduct preliminary analysis of the survey data provided by the five survey participants who had used specialised services, to understand the types of services that they had used, and if there had been any change in their PGSI scores between their initial and follow-up surveys

3.5 EVALUATION RESULTS

3.5.1 Analysis of webinar polling question responses

A total of 20 participants attended webinar 1, 22 attended webinar 2 and 16 attended webinar 3 (Table 13). Since participants attended the webinars anonymously, we were unable to know what proportion of the participants were from the two participating general practices.

Table 13 Webinar attendance

	Chinese webinar	**Korean webinar**	**English webinar**	**Total**
Webinar 1	13	4	3	20
Webinar 2	11	10	1	22
Webinar 3	7	7	2	16

During each webinar, three live polling questions were run to gather immediate responses from the attendees. Each set of poll questions measured attendees' different behaviours, attitudes or knowledge concerning harmful gambling relevant to the presented webinar topic. Attendees answered each question by providing their answers on a 10-point rating scale (see Appendix 9 for the poll questions of the three webinars).

The response rates for the polling questions were very high (Table 14). The majority of respondents attended the entire webinar and answered all poll questions.

Table 14 Number of poll responses (N) and response rates (R)

	Chinese webinar		Korean webinar		English webinar	
	N	R	N	R	N	R
Webinar 1 polling question 1	13	100%	4	100%	*	*
Webinar 1 polling question 2	13	100%	4	100%	3	100%
Webinar 1 polling question 3	13	100%	4	100%	3	100%
Webinar 2 polling question 1	11	100%	10	100%	1	100%
Webinar 2 polling question 2	11	100%	10	100%	0	0%
Webinar 2 polling question 3	11	100%	10	100%	1	100%
Webinar 3 polling question 1	7	100%	7	100%	1	50%
Webinar 3 polling question 2	6	85.7%	7	100%	1	50%
Webinar 3 polling question 3	6	85.7%	7	100%	1	50%

*Due to a technical problem, poll responses were not recorded

The average ratings of attendees' responses to the nine questions were calculated (see Appendix 10). The intended outcomes were that attendees would achieve average scores of at least 6 out of 10 in the nine poll questions associated with the following four target outcome areas:

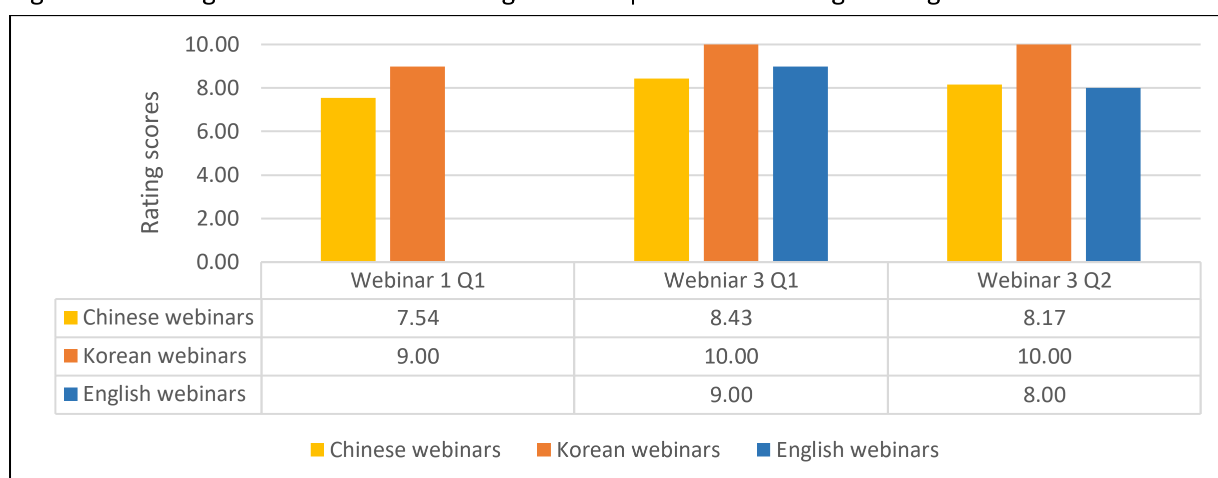
- at least moderate understanding of the impacts of harmful gambling
- at least moderate awareness of the warning signs of harmful gambling
- at least some increase in knowledge on how to prevent and minimise gambling harm and where to get professional help
- the skills for managing stress and self-care introduced in the seminar were at least somewhat helpful

The poll results associated with the four target outcome areas are presented below.

- *at least moderate understanding of the impact of stress on health, the challenges of immigration and how immigrants might be vulnerable to gambling harm, and the impact of gambling on family.*

Webinar 1 presented the impact of stress. Polling Q1 responses indicated that after the webinar, most of the Korean attendees had "excellent understanding" of the impact of stress on health, and Chinese attendees had "moderate understanding" of the topic. Webinar 3 covered immigration challenges and the impact of gambling. Polling Q1 results showed that most of the attendees found the Tree Model "extremely helpful" in helping them understand how immigrants might be vulnerable to gambling-related harm. In addition, polling Q2 results indicated that most of the attendees had "excellent understanding" of the impact that problem gambling has on individuals and families (Figure 18).

Figure 18 Rating scores on understanding of the impacts of harmful gambling



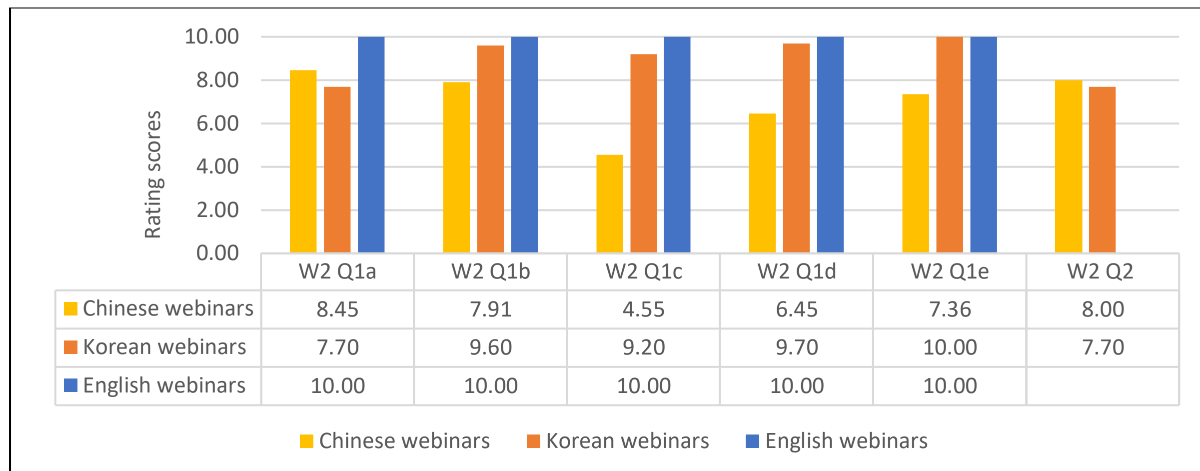
	Webinar 1 Q1	Webinar 3 Q1	Webinar 3 Q2
Chinese webinars	7.54	8.43	8.17
Korean webinars	9.00	10.00	10.00
English webinars		9.00	8.00

Webinar 1 Q1: How well do you understand the impact of stress on cognitive, physical, emotional and behavioural symptoms?
Webinar 3 Q1: How helpful was the 'Tree Model' in helping you understand the struggles of migration as one of the causes of gambling?
Webinar 3 Q2: How well do you understand the emotional, psychological, financial and social impact of problem gambling?

- *at least moderate awareness of the harm of gambling activities, and the warning signs of harmful gambling in the family.*

Webinar 2 discussed different methods of gambling and the warning signs of harmful gambling in the family. All attendees of the Korean and English webinars found online gambling "extremely harmful". Most of them also found sports betting, casino gambling and lottery "extremely harmful" and gambling machines "somewhat harmful" to "extremely harmful". In comparison, the corresponding ratings among Chinese attendees were lower; of note was their average rating of casino gambling at 4.55, or in the "somewhat harmful" to "not harmful" range. Attendees on average also found the warning signs of harmful gambling presented in Webinar 2 "somewhat useful" to "extremely useful" in helping them identify gambling problems in the family (Figure 19).

Figure 19 Rating scores on awareness of the warning signs of harmful gambling

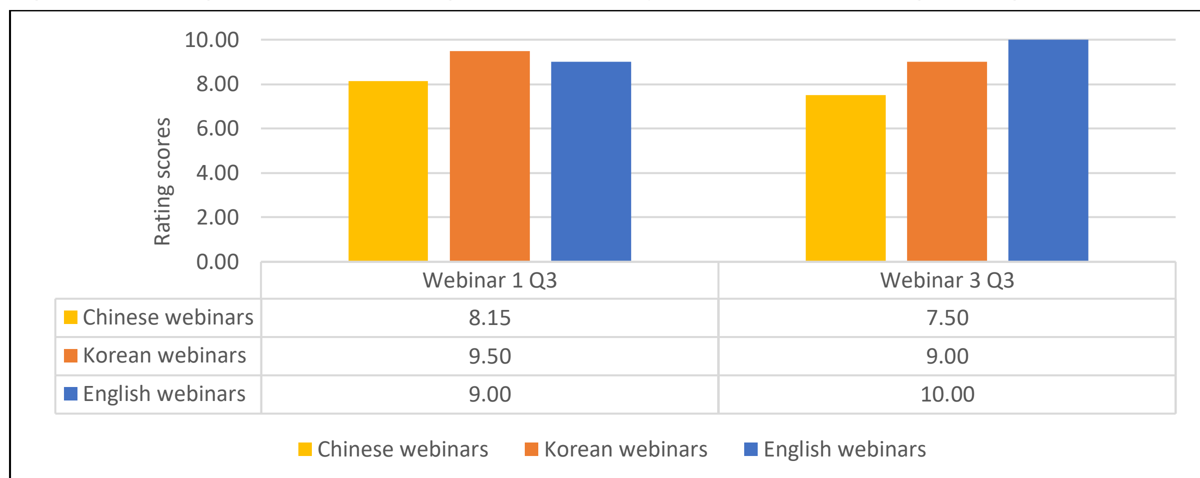


Webinar 2 Q1: How harmful do you consider the following gambling activities: (a) Gaming machines (or Pokies); (b) Lottery; (c) Casino gambling; (d) Sports betting; (e) Online gambling
Webinar 2 Q2: Do you find the warning signs of harmful gambling introduced in this webinar useful in helping people identify gambling problems in the family?

- *at least some increase in knowledge on how to prevent and minimise gambling harm, and where to get professional help*

In all webinars, professional support services provided by AFS for people with harmful gambling and mental health issues were introduced. Through Webinar 1 polling Q3, attendees were asked to rate whether their knowledge on available support services for Asian people has increased or not. The results indicated that after the webinars, most attendees had "a lot of increase in knowledge" on available support services for Asian people. Webinar 3 provided some strategies to prevent gambling harm. Polling Q3 results indicated that after the webinar, most attendees had "a lot of increase in knowledge" on how to prevent and minimise gambling harm (Figure 20).

Figure 20 Rating scores on knowledge about how to prevent and minimise gambling harm

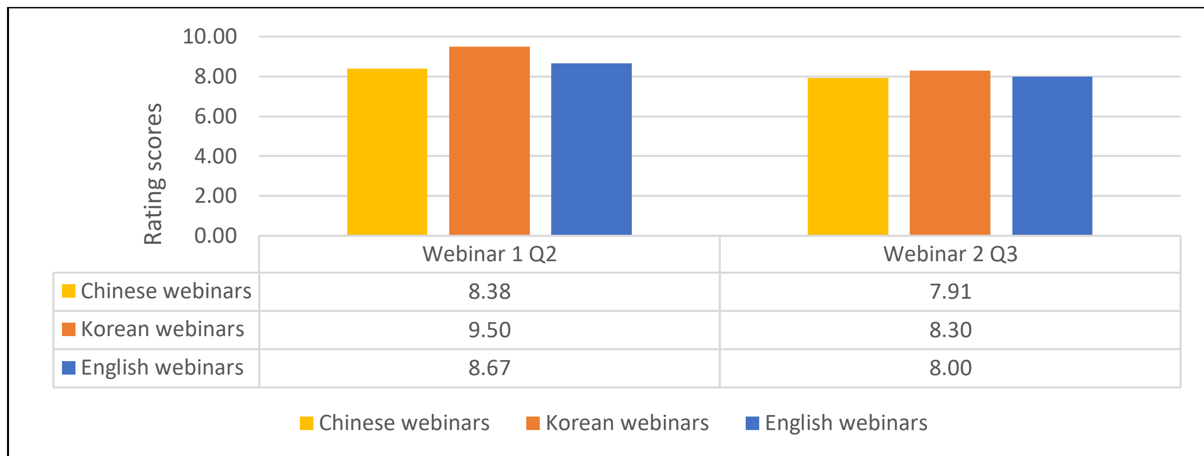


Webinar 1 Q3: Has your knowledge on available mental health support services for Asian people increased after this webinar?
Webinar 3 Q3: Has you knowledge on how to prevent and minimise gambling harm increased after the webinar?

- *The skills for managing stress and self-care, and the strategies to help someone else's harmful gambling introduced in the webinars were at least somewhat helpful*

Webinar 1 introduced deep breathing exercises to manage stress and some self-care tips. Polling Q2 results indicated that most of the webinar attendees found the stress management techniques "extremely helpful". Webinar 2 introduced some strategies to help someone else's harmful gambling, including how to start a conversation about gambling issues, how to help with financial management and how to seek professional support. Polling Q3 results indicated that most of the attendees said they were "somewhat likely" to "extremely likely" to apply the strategies, if their loved ones are affected by harmful gambling (Figure 21).

Figure 21 Rating scores on skills for stress management and self-care



Webinar 1 Q2: Do you find the techniques introduced in this webinar help you to manage stress you are experiencing?

Webinar 2 Q3: If you are concerned about someone's harmful gambling, how likely would you apply the strategies introduced in this webinar to help yourself and your loved ones?

The above results show that overall, the webinar series had achieved the intended outcomes. Further discussion of the findings will be made in Section 3.6.

3.5.2 Analysis of feedback from webinar presenters

The webinar presenters were interviewed in August 2021 to provide feedback on their experience of delivering webinars, and to review the webinar content and make suggestions for future improvements. A simple qualitative analysis was used to group similar findings and ideas. The information was compared to ensure different and similar ideas and issues were identified.

- *Webinar presenters' experience of online webinar delivery*

Two presenters had not delivered online webinars before. The experience was challenging not knowing who the viewers were. Both presenters were very happy with the support provided by the research team – from helping to design the content of the webinar series to setting up test runs and providing technical support during the live webinar sessions. Both felt that they had become more comfortable and confident as the series went on. The third presenter had delivered online webinars before, and felt confident in that aspect. All webinars went well except for one webinar with some responses to polling questions not recorded when the Zoom was disconnected for about 10 seconds.

- *Webinar content and suggestions for future improvements*

Some attendees gave feedback to the presenters, informing that they found the webinars informative and educational, and that they had gained a lot of understanding on harm minimisation. One attendee pointed out that the webinars allowed some Asian people who take part in activities that they do not

usually consider as gambling to reflect on the harm of these activities. The webinars also provided information and support for families affected by gambling.

Webinar presenters commented on webinar attendance. They were aware that Asian people were reluctant to disclose their problematic gambling to others due to a public stigma towards gambling. Since webinar attendees could remain anonymous to other attendees at the webinars, the experienced counsellors who presented the webinars advised that webinar attendance was already better than what they could get from face-to-face seminars. Also, more people participated in webinars delivered in Mandarin and Korean than those delivered in English. This suggests that delivering the webinars in different Asian languages could improve accessibility. In order to better engage their audience, presenters said they had tried to extend on topics that they believed to be more relevant to their particular ethnic group. For example:

- The effects of gambling harm on families (Korean)
- Early identification and intervention of emotional issues (Chinese)
- Importance of mental wellbeing and self-care (South Asian)

Presenters also provided the following suggestions for consideration in the planning of future webinars:

- Instead of using the word 'gambling' directly, put the focus on wellness
- Modify the webinar content to focus on health and wellness; use gambling as a case study to showcase the negative effects
- More information on how to self-care
- Foster compassion and hope and how gambling is something that can be worked through
- Promote the guided self-help resource across multiple channels
- Share the recorded webinars more widely to the Asian communities. Use a tracker to see the number of views (which can give us an idea of reach)
- Avoid delivering the webinars at dinner time – which is usually family time.

3.5.3 Analysis of the survey results of participants who had used primary care-based interventions

The primary aim of the evaluation of Part 2 research was to identify whether general practice can provide a setting for facilitating Asian people's access to interventions for harmful gambling. Language barriers, not knowing where to get help, and cultural barriers such as shame and stigma associated with admitting problems and seeking help, have been identified as key barriers to Asian people's access to harm minimisation services and related specialised support services (Sobrun-Maharaj et al, 2012; Tse, Wong & Chan, 2007). The early interventions developed in this project were designed to address these barriers, by improving accessibility through providing the services in multiple Asian languages, delivering the services through general practices, and reducing stigma by allowing users of some of the services (the guided self-help resource, online webinar and Asian Helpline) to remain anonymous. A follow-up survey was undertaken to identify what proportions of low-risk, moderate-risk and problem gamblers might have used the services, and if there had been any changes in their PGSI scores after using the services.

Due to the Delta outbreak in Auckland between August and December 2021, the implementation of the follow-up survey was greatly impacted. Only 20 survey responses were received, with five (25%) reported that they had used one or more of the specialised services provided by AFS. Two of the five service users were low-risk gamblers as measured by PGSI in the follow-up survey, and three were non-gamblers. No participant in the follow-up survey was moderate-risk or problem gambler.

As only a small proportion of initial survey participants took part in the follow-up survey, and the demographic characteristics (Table 8) and the proportions of participants across different gambling

risk levels in the two surveys were not similar, full evaluation of the extent of low-risk, moderate-risk and problem gamblers accessing specialised services through general practices is deemed to be not feasible. Below is a preliminary analysis of the data provided by the five participants who had used specialised services (Table 15), although the findings may not be generalisable.

Table 15 Survey results of participants who had used specialised services

#						
1	***Participant profile***					
	Ethnic group: Chinese	Gender: Female	Age group: 40-49 years		Country of birth: China	
	Year of arrival to NZ: 2000-2009	Marital status: Married	Citizen / migrant status: Permanent resident		Employment status: Full-time employed	
	Educational attainment: Postgraduate/Masters/Doctoral degree		English proficiency: Very well			
	Initial survey results					
	Self-rated health status: Very good					
	Level of psychological distress: Moderate (K10=16)		Seek help: Yes Help-seeking source: Friend			
	Level of gambling severity: Non-gambler (PGSI=0)		Seek help: No			
	Follow-up survey results					
	Self-rated health status: Fair					
	Level of psychological distress: Moderate (K10=18)					
	Level of gambling severity: Low-risk gambler (PGSI=2)					
	Specialised services used			Wellness Services	Asian Helpline	Counselling services
	Satisfaction level			Very satisfied	Very satisfied	Very satisfied
2	***Participant profile***					
	Ethnic group: Chinese	Gender: Male	Age group: 30-39 years		Country of birth: China	
	Year of arrival to NZ: 2000-2009	Marital status: Married	Citizen / migrant status: Permanent resident		Employment status: Full-time employed	
	Educational attainment: Bachelor's degree		English proficiency: Poor			
	Initial survey results					
	Self-rated health status: Excellent					
	Level of psychological distress: Moderate (K10=16)		Seek help: No			
	Level of gambling severity: Non-gambler (PGSI=0)		Seek help: No			
	Follow-up survey results					
	Self-rated health status: Excellent					
	Level of psychological distress: Moderate (K10=17)					
	Level of gambling severity: Low-risk gambler (PGSI=2)					
	Specialised services used			Wellness Services	Asian Helpline	
	Satisfaction level			Extremely satisfied	Extremely satisfied	
3	***Participant profile***					
	Ethnic group: Korean	Gender: Female	Age group: 30-39 years		Country of birth: South Korea	
	Year of arrival to NZ: 1980-1989	Marital status: Married	Citizen / migrant status: Permanent resident		Employment status: Not employed	
	Educational attainment: Bachelor's degree		English proficiency: Poor			
	Initial survey results					
	Self-rated health status: Good					
	Level of psychological distress: Moderate (K10=17)		Seek help: Yes Help seeking source: Counsellor			
	Level of gambling severity: Non-gambler (PGSI=0)		Seek help: No			

<table>
<tr><td></td><td colspan="6">Follow-up survey results</td></tr>
<tr><td></td><td colspan="6">Self-rated health status: Excellent</td></tr>
<tr><td></td><td colspan="6">Level of psychological distress: Moderate (K10=18)</td></tr>
<tr><td></td><td colspan="6">Level of gambling severity: Non-gambler (PGSI=0)</td></tr>
<tr><td></td><td colspan="2">Specialised services used</td><td>Self-help resource</td><td></td><td></td><td></td></tr>
<tr><td></td><td colspan="2">Satisfaction level</td><td>Very satisfied</td><td></td><td></td><td></td></tr>
<tr><td>4</td><td colspan="6">Participant profile</td></tr>
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40-49 years</td><td colspan="2">Country of birth:
South Korea</td></tr>
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Secondary school qualification</td><td colspan="4">English proficiency:
Fair</td></tr>
<tr><td></td><td colspan="6">Initial survey results</td></tr>
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<tr><td></td><td colspan="2">Level of psychological distress:
Moderate (K10=17)</td><td colspan="4">Seek help: No</td></tr>
<tr><td></td><td colspan="2">Level of gambling severity: Non-gambler (PGSI=0)</td><td colspan="4">Seek help: No</td></tr>
<tr><td></td><td colspan="6">Follow-up survey results</td></tr>
<tr><td></td><td colspan="6">Self-rated health status: Good</td></tr>
<tr><td></td><td colspan="6">Level of psychological distress: Moderate (K10=14)</td></tr>
<tr><td></td><td colspan="6">Level of gambling severity: Non-gambler (PGSI=0)</td></tr>
<tr><td></td><td colspan="2">Specialised services used</td><td></td><td>Wellness Services</td><td></td><td></td></tr>
<tr><td></td><td colspan="2">Satisfaction level</td><td></td><td>Neither satisfied nor dissatisfied</td><td></td><td></td></tr>
<tr><td>5</td><td colspan="6">Participant profile</td></tr>
<tr><td></td><td>Ethnic group: Japanese</td><td>Gender: Female</td><td colspan="2">Age group: 50-59 years</td><td colspan="2">Country of birth: Japan</td></tr>
<tr><td></td><td>Year of arrival to NZ:
2000-2009</td><td>Marital status:
Separated</td><td colspan="2">Citizen / migrant status:
Permanent resident</td><td colspan="2">Employment status:
Not employed</td></tr>
<tr><td></td><td colspan="2">Educational attainment: Certificate/Diploma</td><td colspan="4">English proficiency: Fair</td></tr>
<tr><td></td><td colspan="6">Initial survey results</td></tr>
<tr><td></td><td colspan="2">Self-rated health status: Poor</td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td></td><td colspan="2">Level of psychological distress:
Very high (K10=41)</td><td colspan="4">Seek help: Yes
Help-seeking source: GP</td></tr>
<tr><td></td><td colspan="2">Level of gambling severity: Non-gambler (PGSI=0)</td><td colspan="4">Seek help: No</td></tr>
<tr><td></td><td colspan="6">Follow-up survey results</td></tr>
<tr><td></td><td colspan="6">Self-rated health status: Poor</td></tr>
<tr><td></td><td colspan="6">Level of psychological distress: Very high (K10=36)</td></tr>
<tr><td></td><td colspan="6">Level of gambling severity: Non-gambler (PGSI=0)</td></tr>
<tr><td></td><td colspan="2">Specialised services used</td><td></td><td>Wellness Services</td><td></td><td>Counselling services</td></tr>
<tr><td></td><td colspan="2">Satisfaction level</td><td></td><td>Very satisfied</td><td></td><td>Neither satisfied nor dissatisfied</td></tr>
</table>

Examination of the survey results provided by the five participants showed that the two participants who were low-risk gamblers in the follow-up survey were also identified as having moderate level of emotional distress. The three non-gamblers had varying levels of emotional distress: ranging from low (1) to moderate (1) and very high (1). There were changes in participants' gambling risk levels and emotional distress levels between the two surveys. Three participants remained as non-gamblers but two changed from non-gamblers to low-risk gamblers. One participant's level of emotional distress changed from moderate to low, while the remaining four stayed at the same level (three at moderate level and one at very high level) between the two surveys.

Three participants had used two or more specialised services provided by AFS. AFS Wellness Services were used by the largest number of participants (4), followed by Asian Helpline (2), counselling services (2) and the guided self-help resource (1). Most of the participants who were highly satisfied or extremely satisfied with the services that they had used. Looking into their initial survey results, their help seeking sources were more limited. One participant with very high level of emotional distress sought help from the GP. Out of the remaining four participants who had moderate level of emotional distress, only one had sought help from a counsellor and one from their friends. These early findings will be discussed further in Section 3.6 below.

3.6 DISCUSSION

3.6.1 Impacts of Auckland lockdown on Part 2 research

Part 2 of the research project took place amid the COVID-19 Delta outbreak which has plunged Auckland into lockdown between August and December 2021. The number of people who had completed the follow-up survey was much lower than expected. Of the 165 emails or text messages which were successfully sent, 20 (12.1%) completed responses were received. One hundred and seven (64.8%) had started the survey before the lockdown but did not complete/submit them. 38 (23%) did not attempt the survey.

In our initial survey, we received a majority of the survey responses within the first three weeks, and subsequent survey reminder emails further improved response rate. We were unable to achieve similar results in the follow-up survey. The circumstances under which the two surveys were undertaken were quite different. The initial survey in Clinic A took place when Auckland was moving down alert levels (from level 3 to 2), and the survey in Clinic B took place when Auckland was at alert level 1. But the follow-up survey took place during COVID-19 Delta outbreak and level 4 lockdown. Delta is a much more contagious variant of coronavirus. In the midst of Auckland's longest alert level 4 lockdown, AFS frontline workers had observed that Asian people were finding this lockdown more challenging than those they had endured previously. There were increased pandemic-related anxiety and mental distress, feelings of isolation and vulnerability, as well as uncertainty and worries about the future. Under these circumstances, taking part in the follow-up survey did not seem to be a priority for the majority of potential survey participants.

At a time when New Zealand was putting its major effort into controlling the COVID-19 Delta outbreak, there was little that the research team could do to improve the survey response rate. In the initial survey, clinic staff had helped to promote the survey to their enrolled patients. But when Auckland was in level 4 lockdown, telephone/video consultations were used as much as possible in GP clinics to reduce physical contacts with patients. Moreover, there was a lot of other work going on in the clinics, including promoting vaccination uptake, so clinic staff did not have time to provide support for our survey this time. Survey fatigue was yet another challenge we faced. We were aware that during level 4 lockdown, there were other surveys being conducted to collect the views of Asian communities regarding information access about the lockdown and COVID-19 (e.g. TANI, 2021).

Despite the low completion rate of the follow-up survey, among the 165 people who were sent the follow-up survey, only three (1.8%) had unsubscribed from our emails. The majority had allowed us to keep their details for further contact and services. This is a positive response from the target population. As AFS develops more webinars, online resources and other new services in the future, AFS can use a targeting and segmentation approach, rather than a 'catch all' approach, to target small segments of people for specific resources or services. For example, use different social media platforms to engage different Asian ethnic subgroups, or tailor messages to different groups (e.g. old versus young) for more personalised engagement.

3.6.2 Stepped care support for Asian people

There are limited gambling harm support services for Asian people in New Zealand. The development of a guided self-help resource and the online webinar series in this project aligns with AFS's stepped care approach, which involves providing services across the spectrum of harmful gambling, from self-management (e.g. the guided self-help resource), brief intervention (e.g. online webinars, AFS Wellness Service) through to specialist services (e.g. Asian Helpline, counselling services). By delivering the stepped care intervention in multiple Asian languages, we make services culturally responsive and more accessible, in order to facilitate early intervention work.

We did not collect any personal information from people who accessed the guided self-help resource and online webinars, so users could remain anonymous. Due to the stigma of harmful gambling, Asian people tend to present late to counselling and other treatment services (Sobrun-Maharaj et al., 2012; Tse, Wong & Chan, 2007). Guided self-help resource and online webinars may be the first forms of help that they use. Information about further stepped care intervention, such as the Asian Helpline, is provided in the resource and at the webinars, which users can access when they feel ready to take the next step. For AFS Wellness Services, they were available in one of the participating GP clinics. Patients enrolled in the clinic were referred to AFS Wellness Services by their GPs for brief health interventions and cultural support by health improvement practitioners based in the clinic. For those needing further support for issues related to mental health and addictions, their care could be "stepped up" to more specialised services such as counselling, or secondary mental health and addictions care.

Due to the low response rate of the follow-up survey, only five respondents had used one or more of AFS's stepped care intervention, and they (three non-gamblers and two low-risk gamblers) did not represent the full spectrum of gambling severity. Although we were unable to examine the full extent of stepped care intervention for Asian people with, or at risk of, harmful gambling in this project, early findings from the follow-up survey suggest that the stepped care approach could reach the target population that the intervention is intended for. All five participants who had used AFS stepped care support had mild to moderate mental health and/or gambling issues (Table 15).

Moreover, three of the four AFS Wellness Services users used further stepped care interventions, including the Asian Helpline and counselling services; whereas in the initial survey, their help-seeking behaviour was rather limited, with only one who had sought formal help from a professional. These results suggest that a stepped care model can provide the necessary steps towards addressing Asian people's mental health and addiction issues. However, these findings may not be generalisable given the limited number of survey responses. More research is needed to discern the effectiveness of early interventions within a stepped care model for Asian people.

3.6.3 Early intervention for harmful gambling in general practices

General practice plays an increasingly important role in the prevention and early intervention of mental health problems and addictions. A primary aim of this research was to identify whether general practice can provide a setting for facilitating Asian people's access to interventions.

There are numerous sociocultural barriers for Asian people seeking support. In particular, seeking professional help for mental health or addictions issues can carry stigma and shame, which could delay treatment and allow problems to intensify (Guo et al., 2015; Kim & Kendall, 2015). Hence, reducing stigma and increasing help-seeking are considered to be essential for prevention and intervention. General practice is the place where Asian people often turn to, to get support for physical symptoms and health problems. Providing early intervention for harmful gambling through general practice, Asian people may feel more open to address their issues, without the stigma attached to attending specialist treatment services.

As mentioned above, evaluation of this part of the research was greatly affected by the Delta outbreak in Auckland in 2021. Only five of the 20 participants in the follow-up survey had used the stepped care intervention delivered through general practice; all of them were people with mild to moderate mental health and/or gambling problems and had no or limited experiences of seeking professional help previously. Despite the small number, they were the specific group that the early intervention services targeted for. This group of people are often hidden from help, because help-seeking for harmful gambling and mental health issues among Asian people is uncommon, and when it occurs, it is often crisis-driven. By providing more accessible services at general practice settings, the study had reached out to a group of at-risk people who might not have otherwise sought help. These early findings suggest that general practice has the potential to provide a setting for facilitating Asian people's access to interventions. In addition, some ways to improve Asian people's access to services and support can be drawn from the research.

- *Remove language barriers*

Lack of English language proficiency is a key barrier preventing Asian people from using appropriate health and social services and support. Often Asian people are not aware that such services exist because they do not have the language skills to access the information (Ho et al., 2002). Providing interventions relevant to the cultural and linguistic needs of Asian people can improve their access to services.

- *Reduce the stigma of help-seeking*

The fear about being stigmatised by others often leads to Asian people to avoid seeking professional help (Tse, Wong & Chan, 2007). To help Asian people overcome this barrier to help-seeking, assurance of confidentiality is important. Asian people are particularly concerned about confidentiality if they come from small ethnic communities and the Asian staff providing services are also from the same communities (Ho, Feng & Wang, 2021). Some Asian people prefer to use telephone/online counselling and online webinars over in-person counselling and workshops to give themselves an additional layer of security and privacy, as their identities can remain anonymous.

- *Reframe content: focus on wellness, rather than focusing on problems*

Some problem gambling counsellors involved in this study suggested that the content of community education to address gambling harms in Asian communities should focus on wellness and self-care, rather than focusing on problems. They believed that the word 'problem' was a barrier preventing Asian people from accessing services; reframing the message could be helpful in overcoming shame and stigma associated with help-seeking.

4. IMPLICATIONS AND CONCLUSION

This research was funded through the Ministry of Health Gambling Innovation Research and Evaluation Fund to develop and test an initiative to enable early identification of harmful gambling in primary healthcare settings. Early intervention resources were developed and delivered through general practices to facilitate Asian people's access to interventions and other professional support services. This section discusses the implications of the research for policy and service delivery.

4.1 IMPLICATIONS FOR POLICY

The Government Inquiry into Mental Health and Addiction report (2018) identified the need to transform the primary care sector, with a strong policy focus on supporting primary and community providers to deliver more and different services for people with mental health and addiction needs, particularly people with mild to moderate and moderate to severe mental health and addiction needs. The upcoming health sector reforms also recognise the need to transform the primary healthcare system and to improve equity of access to care (Department of Prime Minister and Cabinet, 2021).

The initiative developed and tested in this research can contribute to this change. Through screening 305 Asian adults enrolled in two GP clinics for gambling, other addictions and mental health problems, the study had found that around one in five Asian respondents were identified as having problems with gambling across a spectrum of severity (8.3% low-risk, 6% moderate-risk and 5.6% problem gambling as measured by *The Problem Gambling Severity Index,* PGSI). In the NZ National Gambling Study (2012 -2015) and the Health and Lifestyle Survey (2014 and 2016), the rates of problem gambling among Asian adults ranged from 0% to 1.3%, moderate-risk gambling from 1.3% to 2.8%, and low-risk gambling from 3.2% to 5.8%. Overall, the rate of Asian people with, or at risk of, harmful gambling (19.9%) found in the study conducted in general practices was 10% to 14% higher than the results from the National Gambling Study and the Health and Lifestyle Survey. In addition, the survey conducted in GP clinics also revealed co-existing issues amongst moderate-risk and problem gamblers, and 2.6% of survey respondents reported that their family members gambled a moderate amount.

These results support the notion that primary care can provide an important setting for early identification of gambling risk and co-existing issues among Asian adults. Harmful gambling is often under-reported by Asian people due to fear of stigma and embarrassment; however, the familiar and trustful setting of general practices can help to reduce Asian people's fear of stigma and facilitate them to disclose their gambling problems.

Key policy implications of the research include:

- Stigma is a key barrier preventing Asian people from disclosing their harmful gambling and associated health issues to others. Primary care can provide an important setting for early identification of gambling risk, hazardous drinking, smoking, drug use and other mental health concerns amongst Asian adults. The familiar and trustful setting of general practices can help to reduce Asian people's fear of stigma and facilitate them to disclose their gambling problems and co-existing issues.
- General practices also have the potential to provide a setting for addressing Asian people's gambling, other addictions and mental health issues. A stepped care approach to deliver early interventions through general practices improves service accessibility by offering greater choices for Asian people to address their holistic concerns. Improved access to primary and community-based services can contribute towards secondary prevention of those at higher risk of experiencing gambling and mental health problems.

4.2 IMPLICATIONS FOR PRACTICE

Gambling is a problematic issue in New Zealand's Asian communities, but Asian people are often reluctant to seek help. There are numerous sociocultural barriers for Asian people to seek professional help for mental health and addictions issues, which could delay treatment and allow problems to intensify. General practice, which carries less stigma and shame than secondary mental health services, has the potential to provide a setting for facilitating Asian people's access to interventions.

A stepped care approach was used in this research to deliver early interventions for harmful gambling, other addictions and mental health issues through general practices, ranging from self-management (guided self-help resource), brief interventions (online webinars, Wellness Services) through to specialist services (Asian Helpline, counselling services). The study found that the Asian respondents who had used one or more stepped care services delivered through general practices were people with mild to moderate mental health and/or gambling problems, and had no or limited experiences of seeking professional help previously.

These findings provided some evidence that primary care-based stepped care interventions can increase help-seeking amongst Asian people, especially people with mild to moderate mental health and addictions needs. The stepped care model helps to increase help-seeking by offering greater choices for Asian people to address their holistic concerns. Other ways the study had used to improve Asian people's access to services included: delivering interventions through general practices which is a familiar and trustful setting for Asian people; removing language barriers by providing services in multiple Asian languages; reducing stigma of help-seeking by assurance of confidentiality and anonymity; and reframing the content of community education to focus on wellness and self-care, rather than focusing on problems. Using a combination of strategies, the intervention programme had reached out to a group of at-risk people who might not have otherwise sought help.

Key implications for service delivery include:

- Addressing gambling, mental health and other addiction issues at primary healthcare level can potentially reduce stigma and discrimination attached to these issues, and facilitate early help-seeking for at-risk people who may not have otherwise sought help.
- Developing and delivering culturally and linguistically responsive early interventions through general practices can improve Asian people's access to services.
- Greater collaboration between GP clinics and community health and social service providers can help to develop innovative approaches to health education, promotion and service delivery, which can result in improved health outcomes and efficiency.

4.3 STRENGTHS AND LIMITATIONS OF THE STUDY

This study had several strengths. Using culturally appropriate research design and methods was a notable strength of the study. All researchers shared same ethnic and cultural backgrounds with the study communities, and we used culturally appropriate processes to access participants. Since English is a key barrier for many Asian people living in New Zealand, all study documents (including survey questionnaires) were translated into three main Asian languages (Chinese, Korean and Hindi). The adequacy of translation was ensured by having all translation done by trained translators who were familiar with the cultural references of the target language. Participants were given the opportunity to choose their preferred language to complete the surveys. Second, strong collaboration was established with the two GP clinics involved in the study. They helped us access and recruit participants to take part in the study, using appropriate strategies to ensure that potential participants were well informed before providing consent. Finally, the research had produced a self-guided

resource and an online webinar series tailored to the target population. These resources are available in English, Chinese, Korean and Hindi.

There are certain limitations in this study. As mentioned before, the COVID 19 lockdown had posed a major challenge to this research. Auckland was in lockdown for over one-third of the research time in 2021. This had significantly interrupted our follow-up survey implementation, resulting in low response rate (12.1%). As such, the findings of the follow-up survey may be limited in their representativeness. Another limitation was time constraint. Due to the limitation of time, intervention (i.e. delivering brief intervention resources and online webinars through general practices) was only done for two months (June to August). Given the stigma attached to help-seeking, survey participants might be hesitant to use the resources or services introduced to them. Only a small number of participants in the follow-up survey reported that they had used AFS services. In this regard, participants from Clinic A would be better informed about AFS services because of the provision of AFS Wellness Services in the clinic. Through that service, health improvement practitioners and health coaches are located in the clinic to help patients access services and coordinate support. Future research should extend the intervention period before assessing the effects of intervention services (e.g. reduce gambling risk or improve health outcomes).

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Appendices

Appendix 1 Online survey questionnaire: English (Qualtrics version)

English (United Kingdom)

Introductory Section

Please select your preferred language using the drop-down box above.

请使用上面的下拉框来选择您的语言喜好。

위의 드롭-다운 상자에서 원하는 언어를 선택하십시오.

कृपया ऊपर दिए गए ड्रॉप-डाउन बॉक्स का उपयोग करके अपनी पसंदीदा भाषा चुनें।

Asian Family Services (AFS) has been working with Apollo Medical Centre to offer onsite counselling to Asian people registered at our clinic since 2016. More recently, AFS has also been involved in the Te Tumu Waiora, or To Head Towards Wellness, programme at Apollo.

AFS is planning to introduce new online support services in multiple Asian languages to complement existing face-to-face counselling services (e.g. online self-guided resources, peer support forums and webinars with useful information and professional advice). This survey will help us better understand your needs and your preferences towards using online services.

The survey will ask you questions about your general information, health needs and preferences for online services. It will take about 10 minutes to complete.

Completing the survey is voluntary (your choice), but we do hope you take part to help us develop services to better meet the needs of Asian people aged 14 years and above registered in our clinic.

Your answers will be kept completely confidential. No one will be personally identified when the overall results of the survey are reported.

Every participant who completes the survey will go into a draw to win one of three prizes (a $500, $300 or $200 supermarket voucher). If you wish to participate in the draw, you will need to provide your personal contact details at the end of the survey.

If you have any questions about this survey, please contact Kristy Kang (Project Coordinator at AFS): 09 553 6896 or kristy.kang@asianfamilyservices.nz

You can start the survey by clicking on the arrow below.

Are you:

- Under 14 years
- Over 14 years

Are you a registered patient with:

- Apollo Medical Centre
- Other

Do you belong to any Asian ethnic group?

- Yes
- No

Ineligible

Thank you for your interest in our survey.

Unfortunately, you do not meet our criteria to participate in the survey. We hope you will understand.

If you need someone to talk to, please call the **Asian Helpline (0800 862 342)** to make an appointment.

Section A: General Information

Are you:

- Male

- Female
- Transgender
- Prefer not to say

Which ethnic group/s do you belong to?

- Chinese
- Filipino
- Indian
- Korean
- ______ Other

Please select your age range:

- 14-19 years
- 20-29 years
- 30-39 years
- 40-49 years
- 50-59 years
- 60-69 years
- 70-79 years
- 80-89 years
- 90+ years

Which country were you born in?

- New Zealand
- China
- Hong Kong
- India
- Phillipines
- Sri Lanka
- South Korea
- ______ Other

When did you arrive to live in New Zealand?

- Before 1980s
- 1980-1989
- 1990-1999
- 2000-2009
- 2010-2019
- 2020 and after

What is your marital status?

- Single
- De facto relationship
- Married
- Separated
- Divorced
- Widowed
- Other

Are you:

- NZ Citizen
- Permanent resident
- Work visa holder
- Student visa holder
- Family sponsored migrant
- Other

What is your employment status?

- Full-time employment
- Part-time, temporary or casual employment
- Self-employed
- I am not in paid employment
- Other

What is your highest educational achievement or qualification?

- No formal school qualification
- Primary school qualification
- NZ secondary school qualification
- Overseas secondary school qualification
- Certificate or Diploma
- Bachelor's Degree
- Post-graduate/Master's/Doctorate Degree
- Other

How well can you speak English?

- I do not speak English
- I speak English poorly, not enough to express my health needs
- I speak enough English to express my health needs
- I speak English very well

Section B: Psychological wellbeing

In the past 12 months, would you say that in general your health has been:

- Excellent
- Very good
- Good
- Fair
- Poor

For each question below, please select the option that best describes how you have been feeling during the **past four weeks**:

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
How often did you feel tired for no good reason?	○	○	○	○	○
How often did you feel nervous?	○	○	○	○	○

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
How often did you feel so nervous that nothing could calm you down?	○	○	○	○	○
How often did you feel hopeless?	○	○	○	○	○
How often did you feel restless or fidgety?	○	○	○	○	○

For each question below, please select the option that best describes how you have been feeling during the **past four weeks**:

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
How often did you feel so restless you could not sit still?	○	○	○	○	○
How often did you feel depressed?	○	○	○	○	○
How often did you feel that everything was an effort?	○	○	○	○	○
How often did you feel so sad that nothing could cheer you up?	○	○	○	○	○
How often did you feel worthless?	○	○	○	○	○

Have you tried to get help in the past 12 months to deal with any of the above issues, whether informally from a friend or more formally from a health professional?

○ No
○ Yes

Where did you go for help? Select ALL the options that apply to you:

☐ Friend
☐ Family
☐ GP
☐ Counsellor
☐ Alternative remedies (e.g. Ayurveda, hanbang, traditional Chinese medicine)
☐ Community (e.g. Minister/religious leader, people from community groups)

- [ ] Information from newspapers, TV, websites, social media platforms
- [ ] Other

Section C: Gambling in the household

For each question below, please select the option that best describes your behaviour or feelings as they relate to gambling over the **last 12 months**:

	Never	Rarely	Sometimes	Often	Always
Have you bet more than you could really afford to lose?	○	○	○	○	○
Have you needed to gamble with larger amounts of money to get the same feeling of excitement?	○	○	○	○	○
Have you gone back on another day to try to win back the money you lost?	○	○	○	○	○
Have you borrowed money or sold anything to gamble?	○	○	○	○	○
Have you felt you might have a problem with gambling?	○	○	○	○	○

For each question below, please select the option that best describes your behaviour or feelings as they relate to gambling over the **last 12 months**:

	Never	Rarely	Sometimes	Often	Always
Have people criticised your betting or told you that you had a gambling problem, whether or not you thought is was true?	○	○	○	○	○
Have you felt guilty about the way you gamble or what happens when you gamble?	○	○	○	○	○
Has gambling caused you any health problems, including stress or anxiety?	○	○	○	○	○

	Never	Rarely	Sometimes	Often	Always
Has your gambling caused any financial problems for you or your household?	○	○	○	○	○

Excluding yourself, how much do people in your current household gamble?

- ○ A lot
- ○ A moderate amount
- ○ A little
- ○ None at all
- ○ Not applicable (e.g. live alone)

Have you tried to get help in the **past 12 months** to reduce or stop gambling for yourself or for a member of your family, whether informally from a friend or more formally from a health professional?

- ○ No
- ○ Yes

Where did you go for help? Select ALL the options that apply to you:

- ☐ Friend
- ☐ Family
- ☐ GP
- ☐ Counsellor
- ☐ Alternative remedies (e.g. Ayurveda, hanbang, traditional Chinese medicine)
- ☐ Community (e.g. Minister/religious leader, people from community groups)
- ☐ Information from newspapers, TV, websites, social media platforms
- ☐ [ ] Other

Section D: Alcohol use

In the **past 12 months**, how often did you have a drink containing alcohol?

- ○ Never
- ○ Monthly or less
- ○ 2-4 times a month

- 2-3 times a week
- 4 or more times a week

In the **past 12 months**, how many drinks did you have on a typical day when you were drinking?

- 1-2
- 3-4
- 5-6
- 7-9
- 10 or more

In the **past 12 months**, how often did you have six or more drinks on one occassion?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

Have you tried in the **past 12 months** to get help to reduce or stop drinking, whether informally from a friend or more formally from a health professional?

- No
- Yes

Where did you go for help? Select ALL the options that apply to you:

- Friend
- Family
- GP
- Counsellor
- Alternative remedies (e.g. Ayurveda, hanbang, traditional Chinese medicine)
- Community (e.g. Minister/religious leader, people from community groups)
- Information from newspapers, TV, websites, social media platforms
- ________ Other

Section E: Substance use

How many cigarettes do you smoke on an average day?

- None
- Less than 1 a day
- 1-10
- 11-20
- 21-30
- 31 or more

Have you tried in the **past 12 months** to get help to stop smoking, whether informally from a friend or more formally from a health professional?

- No
- Yes

Where did you go for help? Select ALL the options that apply to you:

- Friend
- Family
- GP
- Counsellor
- Alternative remedies (e.g. Ayurveda, hanbang, traditional Chinese medicine)
- Community (e.g. Minister/religious leader, people from community groups)
- Information from newspapers, TV, websites, social media platforms
- Other

In the **past 12 months**, have you ever used non-prescription drugs for recreational purposes or to get high?

- No
- Yes

Have you tried in the **past 12 months** to get help to stop taking drugs, whether informally from a friend or more formally from a health professional?

- No
- Yes

Where did you go for help? Select ALL the options that apply to you:

- Friend
- Family
- GP
- Counsellor
- Alternative remedies (e.g. Ayurveda, hanbang, traditional Chinese medicine)
- Community (e.g. Minister/religious leader, people from community groups)
- Information from newspapers, TV, websites, social media platforms
- Other

Section F: Preferences towards using online services

Preferences for Online Support Services

Do you have access to the following (select ALL the options that apply to you):

- Smartphone with sufficient data
- Sufficient broadband Internet connection / WiFi
- Tablet
- Laptop with a camera
- Personal Computer with a camera
- None of the above
- Other (please specify):

What attracts you to use online services (select ALL the options that apply to you):

- Convenience / can do it in your own time
- Can get timely support
- Can get support in the privacy of your own space
- No travel involved to seek support
- More cost effective (e.g. no travel costs)
- Flexible / easy to schedule

- ☐ Feel less embarrassed (e.g. less likely other people will find out about online services use)
- ☐ Receive support in a comfortable environment
- ☐ None of the above
- ☐ Other (please specify): ________

Do you have problems with the following (select ALL the options that apply to you):

- ☐ Limited access to the Internet
- ☐ Poor Internet connection
- ☐ Limited access to smartphone/tablet/laptop/PC
- ☐ Do not know how to use smartphone/tablet/laptop/PC
- ☐ Do not have people (e.g. family members or friends) to help with using smartphone/tablet/laptop/PC
- ☐ Cannot find a private place to use online services
- ☐ Cannot find time to use online services
- ☐ Prefer face-to-face interactions
- ☐ Concerned about other people finding out use of online services
- ☐ None of the above
- ☐ Other (please specify): ________

How likely are you to use the following online services?

	Very likely	Likely	Neutral	Unlikely	Very unlikely	Don't know
Self-help resources Information, tools and guidelines that can be used personally for improving and managing wellbeing	○	○	○	○	○	○
Online coaching Personalised online support and coaching developed by a health professional	○	○	○	○	○	○
Peer-support forum Online support groups to share and discuss health experiences	○	○	○	○	○	○

	Very likely	Likely	Neutral	Unlikely	Very unlikely	Don't know
Webinars Free online health education seminars presented by health professionals	○	○	○	○	○	○
Online counselling One-on-one counselling services conducted via video conference (e.g. Zoom or Skype)	○	○	○	○	○	○

What social media platforms do you use (select ALL the options that apply to you):

- ☐ Facebook
- ☐ WeChat
- ☐ Instagram
- ☐ WhatsApp
- ☐ Kakaotalk
- ☐ TikTok
- ☐ Signal
- ☐ Snapchat
- ☐ ______ Other (please specify):

Section G: Final section

Do you have further comments about this survey that you would like to tell us?

[ ]

Final: Prize Entry

Thank you very much for completing this survey. Your answers will help us to develop online services and resources that are appropriate for our Asian communities.

AFS also has a range of useful resources, such as for mental health, wellbeing, parenting and gambling harm. All our resources are culturally and linguistically appropriate and may be available in your preferred language.

Would you be happy to be contacted within the next six months to answer further questions about the services that you have used (if any)? (Saying YES to this question won't commit you, it just means we can contact you to ask if you would like to participate again.)

- Yes, you can contact me and ask if I want to help again
- No, don't contact me again

Please provide us with your contact details below:

Name

Email

Phone Number

Thank you very much for completing this survey. You are now eligible to enter the prize draw!

There are three prizes that **must** be won, including a $500, $300 and $200 supermarket voucher. The winners will be announced in May on the AFS and Apollo Medical Centre websites.

To enter into the draw, please provide your contact details below. Your details will **only** be used for prize purposes and will not be connected to your survey answers.

Name

Email

Phone Number

Thank you again for your participation.

If you need someone to talk to, please call the **Asian Helpline (0800 862 342)** to make an appointment.

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Appendix 2 – Online survey questionnaire: Chinese (Paper version)

亚裔人群关于线上健康服务的调查研究

自 2016 年起，亚裔家庭服务中心（AFS）和阿波罗（Apollo）医疗中心联手一起为在我们诊所注册的亚裔人群提供设在诊所的心理咨询服务。最近以来，亚裔家庭服务中心参与了阿波罗（Apollo）医疗中心的 Te Tumu Waiora 项目（关于促进身心安康的项目）。

AFS 计划引入多亚洲语种的线上支持新服务（例如线上自助资源、提供有用信息和专业建议的同伴支持论坛和网络研讨），旨在对现有的面对面心理咨询服务作补充。

这项调研会询问您关于个人基本情况、健康需求以及您对线上服务喜好的问题。完成问卷会需要大约 10 分钟。

问卷填写是自愿的（您的个人选择），但是我们非常期待您的参与。您的参与会让我们更好的开发新服务来满足在我们诊所注册的 14 岁以上的亚裔人群的健康需求。

您的问卷回答会是完全保密的。我们在汇报调研的总体结果时也不会暴露您的个人身份信息。

如果您填完了问卷，还有机会进入我们的抽奖池，有机会赢取三份大奖（500 纽币、300 纽币或 200 纽币的超市购物券一张）。如果您希望进入抽奖环节，您需要在问卷调查结尾填写您的个人联系方式。

如果您对本次问卷有任何问题，请和 Kristy Kang（AFS 项目协调员）联系，她的电话是 (09 553 6896)，或者电邮给 (kristy.kang@asianfamilyservices.nz).

A. 一般资料

A1. 您的性别是：

- ☐ 男性
- ☐ 女性
- ☐ 性别多样性
- ☐ 不愿意透露

A2. 您属于哪个族裔群体？

- ☐ 华人华裔
- ☐ 菲律宾裔
- ☐ 印度族裔
- ☐ 韩国裔
- ☐ 其他：_______________________

A3. 请选择您的年龄范围：

- ☐ 14 岁到 19 岁
- ☐ 20 岁到 29 岁
- ☐ 30 岁到 39 岁
- ☐ 40 岁到 49 岁
- ☐ 50 岁到 59 岁
- ☐ 60 岁到 69 岁
- ☐ 70 岁到 79 岁
- ☐ 80 岁到 89 岁
- ☐ 90 岁以上

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A4. 您在哪个国家出生？

- ☐ 新西兰
- ☐ 中国
- ☐ 香港
- ☐ 印度
- ☐ 菲律宾
- ☐ 斯里兰卡
- ☐ 南韩
- ☐ 其他：________________________

A5. 如果您不是在新西兰出生，请问您是什么时候来新西兰的？

- ☐ 1980 年以前
- ☐ 1980 年到 1989 年
- ☐ 1990 年到 1999 年
- ☐ 2000 年到 2009 年
- ☐ 2010 年到 2019 年
- ☐ 2020 年及以后

A6. 您的婚姻状况是？

- ☐ 单身
- ☐ 同居关系
- ☐ 已婚
- ☐ 分居
- ☐ 离婚
- ☐ 丧偶
- ☐ 其他：________________________

A7. 您是：

- ☐ 新西兰公民
- ☐ 新西兰永久居民
- ☐ 工作签证持有者
- ☐ 学生签证持有者
- ☐ 家庭担保移民
- ☐ 其他：________________________

A8. 您的工作状态是？

- ☐ 全职工作
- ☐ 兼职或临时工作
- ☐ 自雇工作
- ☐ 我没有带薪工作
- ☐ 其他：________________________

A9. 您的最高学历或资格认证是什么？

- ☐ 没有正规学校学历
- ☐ 小学学历
- ☐ 新西兰中学学历
- ☐ 海外中学学历
- ☐ 中专或大专证书或文凭
- ☐ 大学学士学位
- ☐ 研究生/硕士/博士学位
- ☐ 其他：________________________

A10. 您的英语水平如何？

- ☐ 我不会说英语
- ☐ 我的英语说得不好，不足以表达我的健康需求
- ☐ 我的英语水平能够表达我的健康需求
- ☐ 我的英语水平非常好

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B. 总体健康水平

B1. 在过去 12 个月内，您感觉您的总体健康水平如何？

- ☐ 优秀
- ☐ 优良
- ☐ 良好
- ☐ 一般
- ☐ 差

B2. 对于以下每个问题，请选择出最能表达您在过去**四个星期中**的个人感受的选项。

	总是	经常	有时	很少	从不
您会无缘无故感觉到疲倦吗？					
您感到紧张的频率是：					
您感到心神不宁到无法平复的频率是：					
您感到绝望的频率是：					
您感到不安或烦躁的频率是：					
您感到烦躁到坐立不安的频率是：					
您感到沮丧的频率是：					
您感到做每件事都好费力的频率是：					
您感到难过到任何事也无法让您开心的频率是：					
您感到自我价值感低的频率是：					

B3. 在过去的 12 个月中，您有没有为上述的问题寻求帮助，无论是向朋友求助还是去找专业医护人员？

- ☐ 没有
- ☐ 有

3

B4. 如果你的答案是 "是"， 您从哪里获得帮助？请选择**所有**适合您的选项：

- ☐ 朋友
- ☐ 家人
- ☐ 全科医生
- ☐ 心理咨询师
- ☐ 替代疗法（例如中医、印度传统医学或韩国中草药）
- ☐ 社区（例如牧师、宗教领袖或社区活动的组织者和参与者）
- ☐ 来自报纸、电视、网站或社交媒体的信息
- ☐ 其他：________________________

C. 家庭中和赌博相關的行为

C1. 对于以下每个问题，请选择最能准确描述您**在过去 12 个月内**和博彩相关的行为或感受的选项。

	从不	很少	有时	经常	总是
您投注的金钱是否超出了您所能负担的？					
您需要投注更多金钱来获得相同的刺激感？					
你曾想过有一去赢回以前输掉的金钱吗？					
您有没有借钱或售卖来补贴赌博的开支？					
您是否觉得您的赌博行为是有问题？					
是否有人批评您的赌博行为或告诉您的赌博行为是有问题的，无论您是否认为这是正确的？					
您是否对自己的赌博行为或赌博结果感到内疚？					
赌博曾否给您造成了任何健康问题，包括压力或焦虑？					
您的赌博行为是否给您或您的家庭带来财务问题？					

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C2.除了你以外，现在的家庭成员在赌博上花费多少？

- ☐ 非常多
- ☐ 有一些
- ☐ 很少
- ☐ 没有
- ☐ 此题不适用（比如，自己独居）

C3.在过去的 12 个月中，您有没有尝试寻求帮助以减少或停止自己或家庭成员的赌博行为，无论是向朋友求助还是专业人员？

- ☐ 没有
- ☐ 有

C4. 如果你的答案是 “是”，
从哪里获得帮助？请选择**所有**适合您的选项：

- ☐ 朋友
- ☐ 家人
- ☐ 全科医生
- ☐ 心理咨询师
- ☐ 替代疗法（例如中医、印度传统医学或韩国中草药）
- ☐ 社区（例如牧师、宗教领袖或社区活动的组织者和参与者）
- ☐ 来自报纸、电视、网站或社交媒体的信息
- ☐ 其他：____________________

D. 饮酒

D1.在过去的 12 个月中，您多久喝一次含酒精的饮料？

- ☐ 从不 [请转到 E]
- ☐ 每月 1 次或更少
- ☐ 每月 2 到 4 次
- ☐ 每周 2 到 3 次
- ☐ 每周 4 次或更多

D2. 在过去的 12 个月中，在平常喝酒的日子，您一天能喝多少杯酒？

- ☐ 1 或 2
- ☐ 3 或 4
- ☐ 5 或 6
- ☐ 7 到 9
- ☐ 10 或更多

D3. 在过去的 12 个月中，您曾经喝了六杯酒或更多的情况多吗？

- ☐ 从来没有
- ☐ 每月少于 1 次
- ☐ 每月都有
- ☐ 每周都有
- ☐ 每天或几乎每天

D4.在过去的 12 个月中，您有没有尝试寻求帮助以减少或停止饮酒，无论是向朋友还是专业医护人员求助？

- ☐ 没有
- ☐ 有

D5. 如果你的答案是 “是”，
您从哪里获得帮助？请选择**所有**适合您的选项：

- ☐ 朋友
- ☐ 家人
- ☐ 全科医生
- ☐ 心理咨询师
- ☐ 替代疗法（例如中医、印度传统医学或韩国中草药）
- ☐ 社区（例如牧师、宗教领袖或社区活动的组织者和参与者）
- ☐ 来自报纸、电视、网站或社交媒体的信息
- ☐ 其他：____________________

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E. 吸烟

E1. 您平均一天抽几支香烟?

- ☐ 从不 [请转到 F]
- ☐ 一天少于 1 支
- ☐ 1-10
- ☐ 11-20
- ☐ 21-30
- ☐ 31 支以上

E2.在过去的 12 个月中，您是否尝试过寻求戒烟的帮助，无论是向朋友还是专业人员求助?

- ☐ 没有
- ☐ 有

E3. 如果你的答案是 "是"，
您从哪里获得帮助? 请选择**所有**适合您的选项:

- ☐ 朋友
- ☐ 家人
- ☐ 全科医生
- ☐ 心理咨询师
- ☐ 替代疗法 (例如中医、印度传统医学或韩国中草药)
- ☐ 社区 (例如牧师、宗教领袖或社区活动的组织者和参与者)
- ☐ 来自报纸、电视、网站或社交媒体的信
- ☐ 其他: ____________________________

F. 药物使用

F1. 在过去的 12 个月中，您是否曾经出于娱乐的目的、或者让自己兴奋而使用非处方药物?

- ☐ 没有 [请转到 G]
- ☐ 有过

F3. 在过去的 12 个月中，您是否为了停止使用药物而尝试寻求帮助，不管是向朋友求助还是寻求专业医护人员的帮助?

- ☐ 没有
- ☐ 有

F3. 如果你的答案是 "是"，
您从哪里获得帮助? 请选择**所有**适合您的选项:

- ☐ 朋友
- ☐ 家人
- ☐ 全科医生
- ☐ 心理咨询师
- ☐ 替代疗法 (例如中医、印度传统医学或韩国中草药)
- ☐ 社区 (例如牧师、宗教领袖或社区活动的组织者和参与者)
- ☐ 来自报纸、电视、网站或社交媒体的信
- ☐ 其他: ____________________________

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G. 对线上支持服务的喜好

G1. 您是否有条件使用以下设备或服务（请选择**所有**适合您的选项）：

- ☐ 有足够数据流量的智能手机
- ☐ 有足够流量的宽带或 WiFi
- ☐ 平板电脑
- ☐ 带摄像头的笔记本电脑
- ☐ 带摄像头的个人电脑
- ☐ 以上都不是
- ☐ 其他（请注明）：

____

G2. 吸引您使用线上服务的好处是（请选择**所有**适合您的选项）：

- ☐ 便捷/可以自选时间接受服务
- ☐ 能够获得及时的帮助
- ☐ 可以在自己的私人空间接受服务
- ☐ 不需要交通往返
- ☐ 成本低廉（比如，省去了交通成本）
- ☐ 时间安排灵活
- ☐ 减少尴尬感（比如，不太可能有其他人发现你使用了线上服务）
- ☐ 在舒适的环境中接受帮助
- ☐ 以上都不是
- ☐ 其他（请注明）：

____

G3. 您是否遇到以下的问题？（请选择**所有**适合您的选项）：

- ☐ 不能接入互联网
- ☐ 网络连接信号差
- ☐ 没有条件使用智能手机、平板电脑或个人电脑
- ☐ 不会使用智能手机、平板电脑或个人电脑
- ☐ 找不到人（比如家人或朋友）来指导使用智能手机、平板电脑或个人电脑
- ☐ 找不到私密空间来使用线上服务
- ☐ 找不到时间来使用线上服务
- ☐ 更喜欢面对面的沟通
- ☐ 担心别人会知道自己使用线上服务
- ☐ 以上都不是
- ☐ 其他（请注明）：

____

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G4. 请选择你使用以下线上服务的可能性。

	非常有可能	有可能	中立	不可能	非常不可能	不知道
自助式资源 供个人管理/和促进福祉提升幸福感 的信息、工具和指南						
在线指导 由专业人员开发的个性化的线上支持和指导服务						
同伴支持论坛 分享和讨论健康经验的线上支持小组						
网络研讨会 专业医护人员讲授的免费线上健康教育的讲座研讨						
线上心理咨询 通过视频会议形式（比如 Zoom 或 Skype）展开的一对一的心理咨询服务						

G5. 您使用哪些社交媒体平台？（请选择**所有**适用您的选项）

- ☐ Facebook
- ☐ WeChat 微信
- ☐ Instagram
- ☐ WhatsApp
- ☐ Kakaotalk
- ☐ TikTok 抖音
- ☐ Signal
- ☐ Snapchat
- ☐ 其他 （请注明）： ____________________

G6. 关于本次调研，您还有什么评论想告诉我们的吗？

____

____

____

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8

亚裔家庭服务中心开发了一系列有用的健康资源，比如心理健康、促进身心安康、亲子教育以及了解赌博的危害等。我们所有的资源都是适宜亚洲文化并且兼容亚洲语言的；我们有中文健康资源手册。

您是否乐意让我们在未来六个月内，再次就在线服务使用方面的问题和您联系？（回答“是”并不意味着您需要第二次被调研，只是表明我们可以和您联系，询问您的参与意愿）。

- ☐ 不，请不要再次联系我
- ☐ 是，你们可以联系我，询问我的参与意愿

请提供您的个人联系方式给我们：

姓名 ____________________________

电子邮件 ____________________________

电话号码 ____________________________

感谢您的参与。

您的回答会帮助我们开发出符合我们亚裔社区特点的线上服务和健康资源。

如果您需要和我们沟通，请致电我们的亚裔服务热线 0800 862 342 进行预约。

✂ --

您现在有资格进入抽奖环节。

我们有三份供抽取的奖品，包括了 500 纽币、300 纽币和 200 纽币的超市购物卡各一张。获奖者名单会在五月份在亚裔家庭服务中心以及阿波罗医疗中心的网站上公布。

为确保您顺利进入抽奖池，请提供下面的个人联系方式。您的个人信息只会用于抽奖，并不会和您的问卷结果产生关联。

姓名 ____________________________

电子邮件 ____________________________

电话号码 ____________________________

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Appendix 3 – Online survey questionnaire: Korean (Paper version)

아시안을 위한 온라인 서비스의 선호도 이해를 위한 설문조사

아시안 패밀리 서비스 (AFS)는 아폴로 메디컬 센터와의 협업으로 2016 년도부터 클리닉에 등록된 아시안을 위한 상담서비스을 현지에서 해드리고 있습니다. 최근에, AFS 는 아폴로 클리닉의 "태 투무 와이오라 (Te Tumu Waiora)"라는 건강 증진 프로그램을 함께 하게 되었습니다.

AFS 는 기존의 대면 상담 서비스를 보완하여, 다양한 아시안 언어로, 새로운 온라인 지원 서비스를 계획하고 있습니다 (예, 온라인 셀프-가이드 자료, 그룹 지원 포럼, 그리고 유용한 정보와 전문가들의 조언을 받을 수 있는 온라인 이벤트들). 이 설문은 온라인 서비스 사용과 관련하여 여러분이 필요로 하는 것과 선호하는 것들을 더 잘 이해하기 위한 것입니다.

이 설문은 온라인 서비스를 위해 여러분에 대한 일반 정보, 건강에 필요한 것들과 또한 선호하는 것들을 알아보기 위한 질문들입니다.

설문을 완성하는 것은 자발적인 것(여러분의 선택)이지만, 클리닉에 등록된 14 세 이상의 아시안에게 필요한 서비스를 더욱 잘 발전시킬 수 있도록 여러분이 설문에 참여해주시기를 바랍니다.

여러분의 사적인 답변 내용은 비밀이 철저히 보장됩니다. 설문 결과가 발표되어도 개인 신상정보는 알려지지 않습니다.

설문을 끝낸 참가자는 추첨을 통해 $500, $300, 또는 $200 짜리 슈퍼마켓 상품권 중의 하나를 받으실 수 있습니다. 추첨에 참가하시기를 원하시는 분은 설문 조사를 마친 후, 개인 연락처를 남겨주시기 바랍니다.

설문에 관련하여 궁금하신 점이 있으시면, 크리스티 강 (AFS 연구 프로젝트 담당자)에게 전화나 (09 553 6896) 이메일을 (kristy.kang@asianfamilyservices.nz) 보내주십시오.

A. 일반 개인정보

A1. 성별은:

- ☐ 남성
- ☐ 여성
- ☐ 그 외의 성
- ☐ 대답을 원치 않음

A2. 어느 민족에 속합니까?

- ☐ 중국인
- ☐ 필리핀인
- ☐ 인도인
- ☐ 한국인
- ☐ 기타: ______________________

A3. 당신의 연령대를 선택해주세요

- ☐ 14-19 살
- ☐ 20-29 살
- ☐ 30-39 살
- ☐ 40-49 살
- ☐ 50-59 살
- ☐ 60-69 살
- ☐ 70-79 살
- ☐ 80-89 살
- ☐ 90 살 이상

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A4. 태어난 나라는 어디입니까?
- ☐ 뉴질랜드
- ☐ 중국
- ☐ 홍콩
- ☐ 인도
- ☐ 필리핀
- ☐ 스리랑카
- ☐ 대한민국
- ☐ 기타: ____________________

A5. 뉴질랜드에서 태어나지 않았다면, 언제 뉴질랜드에 오셨습니까?
- ☐ 1980 년대 이전
- ☐ 1980-1989
- ☐ 1990-1999
- ☐ 2000-2009
- ☐ 2010-2019
- ☐ 2020 이후

A6. 결혼 상태에 대하여 답하여 주십시오
- ☐ 미혼
- ☐ 동거
- ☐ 기혼
- ☐ 결별
- ☐ 이혼
- ☐ 사별
- ☐ 기타: ____________________

A7. 비자 상태에 대하여 답하여 주십시오
- ☐ 뉴질랜드 시민권자
- ☐ 영주권자
- ☐ 워크 비자 소지자
- ☐ 학생 비자 소지자
- ☐ 가족 스폰서 이민
- ☐ 기타: ____________________

A8. 취업 상태에 대하여 답하여 주십시오
- ☐ 풀타임 정규직
- ☐ 파트 타임, 임시직 또는 비정규직
- ☐ 자영업
- ☐ 무직자
- ☐ 기타: ____________________

A9. 최종 학력에 대하여 답하여 주십시오
- ☐ 정규 학교 과정을 받지 않음
- ☐ 초등학교 과정
- ☐ 뉴질랜드 중고등학교 과정
- ☐ 해외 중고등학교 졸업
- ☐ 자격증 또는 디플로마
- ☐ 학사과정
- ☐ 준석사/석사/박사과정
- ☐ 기타: ____________________
- ☐

A10. 영어회화는 어느 정도입니까?
- ☐ 가능하지 않음
- ☐ 약간의 대화는 가능하지만, 건강에 필요한 것을 표현할 수 있을 정도는 아님
- ☐ 건강에 필요한 것을 충분히 말 할 정도임
- ☐ 높은 영어 수준

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B. 전반적인 건강상태

B1. 지난 12 개월동안 일반적인 건강 상태는 어땠습니까?
- ☐ 최상으로 좋음
- ☐ 매우 좋음
- ☐ 좋음
- ☐ 보통
- ☐ 나쁨

B2. 아래의 각 질문 사항에 **지난 4 주동안**의 여러분의 감정을 가장 잘 표현한 항목에 답하여 주십시오

	항상	대부분	가끔	잠깐	전혀
얼마나 자주 별다른 이유없이 피곤함을 느꼈습니까?					
얼마나 자주 긴장감을 느꼈습니까?					
얼마나 자주 어떤 것으로도 진정시킬 수 없는 긴장감이 있었습니까?					
얼마나 자주 절망감을 느꼈습니까?					
얼마나 자주 안절부절하거나 초조함을 느꼈습니까?					
얼마나 자주 가만하 앉아있지 못할 정도로 안절부절했습니까?					
얼마나 자주 우울했습니까?					
얼마나 자주 하는 일이 모두 힘들다고 생각 되었습니까?					
얼마나 자주 아무것도 위로가 되지않을 정도로 슬프다고 느꼈습니까?					
얼마나 자주 자신이 쓸모없다고 느껴졌습니까?					

B3. 지난 12 개월동안, 위의 어려움들을 해결하기위해 가까운 지인이나, 혹은 정식으로 건강 전문가에게 도움을 받으려고 한 적이 있습니까?
- ☐ 아니오
- ☐ 네

B4. 만약 그렇다면, 어디에 도움을 요청하셨나요? 해당되는 **모든** 항목을 골라주십시오:

- ☐ 친구
- ☐ 가족
- ☐ 담당 의사
- ☐ 상담사
- ☐ 대체 의학 (예, 인도 전통의학, 한방, 중국 전통 한의학)
- ☐ 커뮤니티(예, 목사/종교 지도자, 커뮤니티 그룹 내 사람)
- ☐ 신문, TV, 웹사이트, 소셜 미디어 등에서의 정보
- ☐ 기타: ______________________

C. 가정내의 도박

C1. 아래의 각 질문 사항에 **지난 12 개월 동안**에 도박과 관련된 여러분의 행동이나 감정을 가장 잘 표현한 항목에 답하여 주십시오

	전혀	거의	가끔	자주	항상
감당할 수 없을 만큼 과도하게 도박을 하신 적이 있었습니까?					
전과 같은 만족감을 얻기 위해 더 큰 액수의 돈을 걸어야 했던 적이 있었습니까?					
잃은 돈을 찾기 위해 다시 도박을 하러 가신 적이 있습니까?					
도박을 하기 위해 돈을 빌리거나, 물건을 판 적이 있습니까?					
본인에게 도박 문제가 있다고 느끼신 적이 있습니까?					
본인의 판단과는 별도로, 주위 사람들이 당신의 도박에 대해 비판하거나, 당신에게 도박 문제가 있다고 말한 적이 있습니까?					
본인의 도박하는 방법이나, 도박을 하면서 발생되는 문제들이 잘못되었다고 느낀 적이 있습니까?					
도박으로 인한 스트레스나 불안감 같은 건강 문제가 있었습니까?					
도박으로 인해 당신이나 당신 가족들에게 경제적 문제가 있었습니까?					

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C2. 당신을 제외하고, 현재 함께 사는 가족들은 도박에 얼마나 많은 돈을 씁니까?
- ☐ 많이
- ☐ 적당히
- ☐ 조금
- ☐ 전혀
- ☐ 관계없음(예, 독거)

C3. 지난 12 개월동안, 당신 또는 가족의 도박을 줄이거나 멈추기 위해, 친구나 가족, 혹은 정식으로 건강 전문가에게 도움을 받으려고 한 적이 있습니까?

- ☐ 아니오
- ☐ 네

C4. 만약 그렇다면, 어디에 도움을 요청하셨나요? 해당되는 **모든** 항목을 골라주십시오:
- ☐ 친구
- ☐ 가족
- ☐ 담당 의사
- ☐ 상담사
- ☐ 대체 의학 (예, 인도 전통의학, 한방, 중국 전통 한의학)
- ☐ 커뮤니티(예, 목사/종교 지도자, 커뮤니티 그룹 내 사람)
- ☐ 신문, TV, 웹사이트, 소셜 미디어 등에서의 정보
- ☐ 기타: ______________________

D. 알콜 사용

D1. 지난 12 개월동안, 얼마나 자주 알콜 음료를 마셨나요?

- ☐ 전혀 [다음 E 문항으로 가주십시오]
- ☐ 한달에 한번이나 그 이하
- ☐ 한달에 2-4 번정도
- ☐ 한주에 2-3 번정도
- ☐ 한주에 4 번이나 그 이상

D2. 지난 12 개월동안, 음주시 보통 몇 잔정도 마셨나요? (한잔 기준; 맥주 한잔- 330ml, 알콜 4%, 또는 와인 한잔-100ml, 알콜 12.5%)
- ☐ 1-2
- ☐ 3-4
- ☐ 5-6
- ☐ 7-9
- ☐ 10 이상

D3. 지난 12 개월동안, 한 번 마실 때 여섯 잔이나 그 이상을 마신 적은 얼마나 자주 있었습니까?
- ☐ 전혀 없었음
- ☐ 한달에 한번 이하
- ☐ 한달에 한번
- ☐ 일주일에 한번
- ☐ 매일 또는 거의 매일

D4. 지난 12 개월동안, 음주를 줄이거나 멈추기 위해 친구나 가족, 혹은 정식으로 건강 전문가에게 도움을 받으려고 한 적이 있습니까?
- ☐ 아니오
- ☐ 네

D5. 만약 그렇다면,어디에 도움을 요청하셨나요? 해당되는 **모든** 항목을 골라주십시오:
- ☐ 친구
- ☐ 가족
- ☐ 담당 의사
- ☐ 상담사
- ☐ 대체 의학 (예, 인도 전통의학, 한방, 중국 전통 한의학)
- ☐ 커뮤니티(예, 목사/종교 지도자, 커뮤니티 그룹 내 사람)
- ☐ 신문, TV, 웹사이트, 소셜 미디어 등에서의 정보
- ☐ 기타: ______________________

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E. 흡연

E1. 보통 하루에 몇 개비의 담배를 피웁니까?
- ☐ 전혀 피지 않음 [다음 F 문항으로 가주십시오]
- ☐ 하루 한개비 이하
- ☐ 1-10
- ☐ 11-20
- ☐ 21-30
- ☐ 31 또는 그 이상

E2. 지난 12 개월동안, 금연을 위해 친구나 가족, 혹은 정식으로 건강 전문가에게 도움을 받으려고 한 적이 있습니까?
- ☐ 아니오
- ☐ 네

E3. 만약 그렇다면,어디에 도움을 요청하셨나요? 해당되는 **모든** 항목을 골라주십시오:
- ☐ 친구
- ☐ 가족
- ☐ 담당 의사
- ☐ 상담사
- ☐ 대체 의학 (예, 인도 전통의학, 한방, 중국 전통 한의학)
- ☐ 커뮤니티(예, 목사/종교 지도자, 커뮤니티 그룹 내 사람)
- ☐ 신문, TV, 웹사이트, 소셜 미디어 등에서의 정보
- ☐ 기타: ______________________

F. 약물 사용

F1. 지난 12 개월동안, 기분 전환의 목적이나, 기분 상승을 위해서 처방 받지 않은 약물을 복용하신 적이 있으십니까?
- ☐ 아니오 [다음 G 문항으로 가주십시오]
- ☐ 네

F2. 지난 12 개월동안, 약물을 끊기 위해 친구나 가족, 혹은 정식으로 건강 전문가에게 도움을 받으려고 한 적이 있습니까?
- ☐ 아니오
- ☐ 네

F3. 만약 그렇다면,어디에 도움을 요청하셨나요? 해당되는 **모든** 항목을 골라주십시오:
- ☐ 친구
- ☐ 가족
- ☐ 담당 의사
- ☐ 상담사
- ☐ 대체 의학 (예, 인도 전통의학, 한방, 중국 전통 한의학)
- ☐ 커뮤니티(예, 목사/종교 지도자, 커뮤니티 그룹 내 사람)
- ☐ 신문, TV, 웹사이트, 소셜 미디어 등에서의 정보
- ☐ 기타: ______________________

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G. 온라인 지원 서비스를 위한 선호도

G1. 다음 중 이용 가능한 기기/서비스를 선택해주십시오 (해당되는 **모든** 항목을 골라주십시오):
- ☐ 충분한 데이터를 쓸 수 있는 스마트폰
- ☐ 충분한 광대역 인터넷 연결/와이파이
- ☐ 태블릿
- ☐ 카메라가 내장된 노트북
- ☐ 카메라가 내장된 개인용 컴퓨터
- ☐ 위에 해당 사항 없음
- ☐ 기타 (자세하게 알려주십시오):

____

G2. 온라인 서비스 이용의 장점은 무엇입니까? (해당하는 **모든** 사항을 선택해주십시오):
- ☐ 편리성/나에게 알맞는 시간에 할 수 있는 점
- ☐ 적절한 시기에 지원을 받을 수 있음
- ☐ 개인 공간에서 지원받을 수 있음
- ☐ 지원을 받기 위해 다른 장소를 갈 필요가 없음
- ☐ 재정적 이점 (예, 교통비 절약)
- ☐ 자유롭고/쉽게 시간 계획이 가능함
- ☐ 심리적 불안감이 낮음 (예, 온라인 서비스 이용을 다른 사람들이 알 수 없다는 이유 등으로)
- ☐ 편안한 공간에서 지원을 받을 수 있는 있음
- ☐ 위에 해당 사항 없음
- ☐ 기타 (자세하게 알려주십시오):

____

G3. 아래 항목 중 본인에게 해당하는 문제들을 골라주십시오(해당하는 **모든** 사항을 선택해주십시오):
- ☐ 인터넷 사용 제한
- ☐ 인터넷 연결이 고르지 않음
- ☐ 스마트폰/태블릿/노트북/PC 사용 제한
- ☐ 스마트폰/태블릿/노트북/PC 사용 방법의 정보 부족
- ☐ 스마트폰/태블릿/노트북/PC 사용을 도와줄 사람 (예, 가족이나 친구)이 없음
- ☐ 온라인 서비스를 이용할 사적인 장소가 없음
- ☐ 온라인 서비스를 이용할 시간이 없음
- ☐ 대면 상호 접촉을 선호함
- ☐ 온라인 서비스 이용을 다른 사람이 알게 될 것을 우려함
- ☐ 위에 해당 사항 없음
- ☐ 기타 (자세하게 알려주십시오):

____

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G4. 아래의 온라인 서비스를 얼마나 잘 이용할 것 같습니까?

	매우 잘 이용함	잘 이용함	보통 정도로 이용함	잘 이용안함	거의 이용안함	잘 모르겠음
자기-돌봄 자료 스스로 건강한 삶 (웰빙)을 향상시키고, 관리할 수 있는 여러 정보와 자료, 지침들						
온라인 코칭 건강 전문가들에 의해 개발된 개인 맞춤형 온라인 지원과 코칭						
그룹 지원 포럼 건강에 대한 경험을 서로 나누고, 토론할 수 있도록 돕는 온라인 그룹 지원 서비스						
인터넷 세미나 건강 전문가들에 의해 제공되는 무료 온라인 건강 교육 세미나들						
온라인 상담 온라인 일대일 화상 비디오 상담(예, 줌 또는 스카이프)						

G5. 사용하시는 소셜 미디어는 어느 것입니까? (해당되는 **모든** 항목을 골라주십시오):

- ☐ 페이스북
- ☐ 위챗
- ☐ 인스타그램
- ☐ 왓츠앱
- ☐ 카카오톡
- ☐ 틱톡
- ☐ 시그널
- ☐ 스냅챗
- ☐ 기타 (구체적으로 알려주십시오): ______________________

G6. 이 설문에 관해 더 나누고 싶은 의견이 있으십니까?

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AFS 는 정신 건강, 웰빙, 육아와 도박 문제와 관련된 여러 가지 다양한 자료들을 가지고 있습니다. 문화적, 언어적 이해를 바탕으로 만들어진 다양하고 유용한 자료들을 여러분이 원하시는 언어로 이용하실 수 있습니다.

추후 6 개월 이내에, 이용하신 서비스 (만약 있으시다면)에 관련된 추가 질문과 답변을 위해 연락을 드려도 괜찮으시겠습니까? (만약 동의하신다면, 재참석하실지 여부를 문의 드릴 수 있습니다.)

- ☐ 아니오, 추후에 연락을 원치 않습니다.
- ☐ 네, 연락을 하고, 제가 다시 참석할지 물어봐도 좋습니다.

아래에 여러분의 연락처를 남겨주시기 바랍니다:

이름 ____________________

이메일 ____________________

전화번호 ____________________

설문에 참여해주셔서 감사합니다.

여러분의 의견은 아시안 커뮤니티를 위한 더욱 적절한 온라인 서비스와 자료를 발전시키는 데에 도움이 될 것입니다.

상담원과 이야기를 나누길 원하시면, **아시안 헬프라인** (0800 862 342)에 연락하여 예약하시기 바랍니다.

✂ -

여러분은 추첨을 통해 상품을 받으실 수 있습니다.

추첨을 통해 세명의 참가자에게 $500, $300 그리고 $200 짜리 슈퍼마켓 부우처를 드립니다. 당첨자는 5 월달에 AFS 그리고 아폴로 메디컬 센터 웹사이트에 발표될 것입니다.

추첨에 참가하시려면, 아래에 연락처를 기재하여 주십시오. 여러분에 연락처는 설문 조사와는 관계없이, 당첨자 추첨에만 사용될 것입니다.

이름 ____________________

이메일 ____________________

전화번호 ____________________

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Appendix 4 – Online survey questionnaire: Hindi (Paper version)

एशियाई लोगों के लिए ऑनलाइन सेवाओं के विकल्प का पता लगाने के लिए सर्वेक्षण

एशियन फैमिली सर्विसज (एएफएस) अपोलो मेडिकल सेंटर के साथ मिलकर 2016 से हमारे क्लिनिक में पंजीकृत एशियाई लोगों को ऑनसाइट परामर्श देने का काम कर रहा है।. हाल ही में, एएफएस ते तुमु वायोरा, या अपोलो के वेलनेस प्रोग्राम में भी शामिल हुआ है।.

एएफएस कई एशियाई भाषाओं में एक नई ऑनलाइन सहायता सेवा शुरू करने की योजना बना रहा है जो मौजूद फेस टू फेस काउंसलिंग सर्विसेज (जैसे ऑनलाइन स्वयं-निर्देशित संसाधन, उपयोगी जानकारी और पेशेवर सलाह के साथ सहकर्मी सहायता फ़ोरम और वेबिनार) में सहायक होगा।. ये सर्वे ऑनलाइन सर्विसेज के प्रति आपकी जरूरतों और पसंद को बेहतर तरीके से समझने में हमारी सहायता करेगा।.

इस सर्वे में आपकी आम जानकारी, स्वास्थ्य संबधी जरूरतों और ऑनलाइन सर्विसेज में आपकी पसंद के बारे में कुछ सवाल पूछे जायेंगे। इस सर्वे में आपका 10 मिनट का समय लगेगा।.

आपके जवाब पूरी तरह से गुप्त रखे जाएंगे। सर्वे के परिणाम में भी आपकी पहचान उजागर नहीं की जाएगी।.
सभी प्रतिभागी जो इस सर्वे को पूरा करेंगे उन्हें ड्रॉ में शामिल किया जायेगा जिसमें वो ($500, $ 300 या $200 के सुपरमार्केट वाउचर) तीनों में से कोई भी एक ईनाम जीत सकते हैं। अगर आप सर्वे में भाग लेना चाहते है तो सर्वे के अंत में आपको अपनी निजी जानकारी उपलब्ध करानी होगी।.

अगर आप सर्वे के बारे में कोई जानकारी चाहते है तो क्रिस्टी कैंग (प्रोजेक्ट कार्डिनेटर एफस) से सम्पर्क कर सकते है।
09 553 6896 or kristy.kang@asianfamilyservices.nz

A. <u>साधारण जानकारी</u>

A1. क्या आप हैं :

- ☐ पुरुष
- ☐ महिला
- ☐ लिंग विविध
- ☐ नहीं बताना चाहते हैं

A2. आप किस जातिय समुह से है?

- ☐ चाइनीज़
- ☐ फिलीपीनो
- ☐ इंडियन
- ☐ कोरियन
- ☐ अन्य: ________________________

A3. कृपया अपनी आयु सीमा चुनें:

- ☐ 14-19 वर्ष
- ☐ 20-29 वर्ष
- ☐ 30-39 वर्ष
- ☐ 40-49 वर्ष
- ☐ 50-59 वर्ष
- ☐ 60-69 वर्ष
- ☐ 70-79 वर्ष
- ☐ 80-89 वर्ष
- ☐ 90+ वर्ष

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A4. आप किस देश में पैदा हुए थे?

- ☐ न्यूज़ीलैंड
- ☐ चाइना
- ☐ हांग कांग
- ☐ इंडिया
- ☐ फिलीपीन्स
- ☐ श्रीलंका
- ☐ साउथ कोरिया
- ☐ अन्य : ____________________________

A5. यदि आप न्यूज़ीलैंड में पैदा नहीं हुए थे तो आप न्यूज़ीलैंड में रहने के लिए कब आये?

- ☐ 1980 से पहले
- ☐ 1980-1989
- ☐ 1990-1999
- ☐ 2000-2009
- ☐ 2010-2019
- ☐ 2020 और बाद में

A6. आपकी वैवाहिक स्थिति क्या है?

- ☐ अविवाहित
- ☐ डीफैक्टो रिलेशनशिप
- ☐ विवाहित
- ☐ अलग हो चुके है
- ☐ तलाकशुदा
- ☐ विधवा
- ☐ अन्य : ____________________________

A7. आप है:

- ☐ न्यूज़ीलैंड के नागरिक
- ☐ स्थायी निवासी
- ☐ वर्क वीजा होल्डर
- ☐ स्टूडेंट वीजा होल्डर
- ☐ फैमिली स्पोन्सर्ड माइग्रेन्ट
- ☐ अन्य : ____________________________

A8. आपके रोजगार की क्या स्थिती है?

- ☐ फुलटाइम रोजगार
- ☐ पार्ट टाईम, अस्थाई या कैजुअल रोजगार
- ☐ स्व रोजगार
- ☐ मैं भुगतान रोजगार में नहीं हूं
- ☐ अन्य : ____________________________

A9. आपकी सर्वोच्च शैक्षिक उपलब्धि या योग्यता क्या है?

- ☐ कोई औपचारिक स्कूल योग्यता नहीं
- ☐ प्राथमिक विद्यालय योग्यता
- ☐ न्यूज़ीलैंड माध्यमिक स्कूल योग्यता
- ☐ ओवसीज़ माध्यमिक विद्यालय योग्यता
- ☐ सर्टिफिकेट या डिप्लोमा
- ☐ स्नातक की डिग्री
- ☐ पोस्ट-ग्रेजुएट / मास्टर / डॉक्टरेट डिग्री
- ☐ अन्य : ____________________________

A10. आप कितनी अच्छी अंग्रेजी बोल सकते हैं?

- ☐ मैं अंग्रेजी नहीं बोलता
- ☐ मैं अंग्रेजी खराब बोलता हूं, अपनी स्वास्थ्य जरूरतों को व्यक्त करने के लिए पर्याप्त नहीं है
- ☐ मैं अपनी स्वास्थ्य आवश्यकताओं को व्यक्त करने के लिए पर्याप्त अंग्रेजी बोलता हूं
- ☐ मैं अंग्रेज़ी बहुत अच्छी तरह बोलता हूं

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B. समग्र स्वास्थ्य

B1. पिछले 12 महीनों में, आप क्या कहेंगे कि सामान्य तौर पर आपका स्वास्थ्य कैसा रहा है:

- ☐ अति उत्कृष्ट
- ☐ बहुत अच्छा
- ☐ अच्छा
- ☐ ठीक
- ☐ खराब

B2. नीचे दिए गए प्रत्येक प्रश्न के लिए, कृपया उस विकल्प का चयन करें जो आपको बताता है कि **पिछले चार सप्ताह** के दौरान आप कैसा महसूस कर रहे हैं:

	पुरे समय	अधिकतर समय	कुछ समय	बहुत थोडा समय	कभी नहीं
बिना किसी उचित कारण के आपको कितनी बार थकान महसूस हुई?					
आपको कितनी बार घबराहट महसूस हुई?					
कितनी बार आपको इतनी घबराहट महसूस हुई कि कुछ भी आपको शांत नहीं कर सका?					
आप कितनी बार निराशाजनक महसूस करते थे?					
कितनी बार आपको बेचैनी या झल्लाहट महसूस हुई?					
कितनी बार आपने इतनी घबराहट महसूस की कि आप स्थिर नहीं बैठ सके?					
कितनी बार आप उदास महसूस करते थे?					
आपने कितनी बार महसूस किया कि ये सबकुछ बस एक प्रयास था?					
कितनी बार आपको इतना दुख हुआ कि कुछ भी आपको खुश नहीं कर पाया?					
आपको कितनी बार लगा कि आप अयोग्य है?					

B3. क्या आपने उपरोक्त किसी भी समस्या से निपटने के लिए **पिछले 12 महीनों** में सहायता प्राप्त करने की कोशिश की है, चाहे वह अनौपचारिक रूप से किसी मित्र से हो या औपचारिक रूप से स्वास्थ्य पेशेवर से?

- ☐ नहीं
- ☐ हाँ

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B4. अगर हां, तो, आप मदद के लिए कहां गए थे? आपके लिए लागू होने वाले **सभी** विकल्पों का चयन करें:

- ☐ मित्र
- ☐ परिवार
- ☐ जीपी
- ☐ परामर्शदाता
- ☐ वैकल्पिक उपचार (उदा। आयुर्वेद, हेंबंग, पारंपरिक चीनी चिकित्सा)
- ☐ समुदाय (जैसे मंत्री / धार्मिक नेता, सामुदायिक समूहों के लोग)
- ☐ समाचार पत्रों, टीवी, वेबसाइटों, सोशल मीडिया प्लेटफार्मों से जानकारी
- ☐ अन्य : ______________________________

C. परिवार में जुआ

C1. नीचे दिए गए प्रत्येक प्रश्न के लिए, कृपया उस विकल्प का चयन करें जो आपके व्यवहार या भावनाओं का सबसे अच्छा वर्णन करता है क्योंकि वे **पिछले 12 महीनों** में जुए से संबंधित हैं:

	कभी नहीं	शायद ही कभी	कभी कभी	बार बार	सदैव
जो शर्त हारना आपके सामर्थ्य में नहीं है,क्या आपने ऐसी शर्त लगाई है?					
क्या आपको उत्साह प्राप्त करने के लिए बड़ी मात्रा में जुआ खेलने की आवश्यकता है?					
क्या आप अपने खोए हुए धन को वापस जीतने की कोशिश करने के लिए दूसरे दिन वापस चले गए हैं?					
क्या आपने पैसे उधार लिए हैं या जुआ खेलने के लिए कुछ भी बेचा है?					
क्या आपने महसूस किया है कि आपको जुए से समस्या हो सकती है?					
क्या लोगों ने आपकी जुए की आलोचना की है या आपको बताया है कि आपको जुए की समस्या है, आपने सोचा कि क्या ये सच है?					
क्या आपने जुआ खेलने के तरीके के बारे में दोषी महसूस किया है या जब आप जुआ खेलते हैं तो क्या होता है?					
क्या जुआ से आपको कोई स्वास्थ्य समस्या है, जिसमें तनाव या चिंता शामिल है?					
क्या आपके जुए ने आपके या आपके घर के लिए कोई वित्तीय समस्या पैदा की है?					

C2. आप को छोड़कर, आपके वर्तमान घर के लोग कितना जुआ खेलते हैं?

- ☐ बहुत
- ☐ एक मध्यम राशि
- ☐ थोड़ा बहुत
- ☐ बिल्कुल भी नहीं
- ☐ लागू नहीं (जैसे अकेले रहते हैं)

C3. क्या आपने **पिछले 12 महीनों** में अपने लिए या अपने परिवार के किसी सदस्य के लिए जुए को कम करने या रोकने के लिए मदद लेने की कोशिश की है, चाहे अनौपचारिक रूप से किसी मित्र से या औपचारिक रूप से किसी स्वास्थ्य पेशेवर से?

- ☐ नहीं
- ☐ हाँ

C4. अगर हां, तो, आप मदद के लिए कहां गए थे? आपके लिए लागू होने वाले **सभी** विकल्पों का चयन करें:

- ☐ मित्र
- ☐ परिवार
- ☐ जीपी
- ☐ परामर्शदाता
- ☐ वैकल्पिक उपचार (उदा। आयुर्वेद, हेंबंग, पारंपरिक चीनी चिकित्सा)
- ☐ समुदाय (जैसे मंत्री / धार्मिक नेता, सामुदायिक समूहों के लोग)
- ☐ समाचार पत्रों, टीवी, वेबसाइटों, सोशल मीडिया प्लेटफार्मों से जानकारी
- ☐ अन्य : ______________________

D. शराब का उपयोग

D1. **पिछले 12 महीनों में,** आपने कितनी बार शराब पी थी?

- ☐ कभी नहीं **[अगले सत्र E में जाएं]**
- ☐ मासिक या उससे कम
- ☐ महीने में 2-4 बार
- ☐ सप्ताह में 2-3 बार
- ☐ सप्ताह में 4 या अधिक बार

D2. **पिछले 12 महीनों में,** जब आप ड्रिंक कर रहे थे, तब एक सामन्य दिन में आप कितने ड्रिंक्स ले रहे थे?

- ☐ 1-2
- ☐ 3-4
- ☐ 5-6
- ☐ 7-9
- ☐ 10 या अधिक

D3. **पिछले 12 महीनों में,** आपने एक अवसर पर कितनी बार छह या उससे अधिक ड्रिंक्स लिए?

- ☐ कभी नहीं
- ☐ मासिक से कम
- ☐ मासिक
- ☐ साप्ताहिक रूप से
- ☐ दैनिक या लगभग दैनिक

D4. क्या आपने पिछले 12 महीनों में शराब पीने को कम या उसे रोकने में मदद ली, चाहे अनौपचारिक रूप से किसी मित्र से या औपचारिक रूप से स्वास्थ्य पेशेवर से?

- ☐ नहीं
- ☐ हाँ

D5. अगर हां, तो, आप मदद के लिए कहां गए थे? आपके लिए लागू होने वाले **सभी** विकल्पों का चयन करें:

- ☐ मित्र
- ☐ परिवार
- ☐ जीपी
- ☐ परामर्शदाता
- ☐ वैकल्पिक उपचार (उदा। आयुर्वेद, हेंबंग, पारंपरिक चीनी चिकित्सा)
- ☐ समुदाय (जैसे मंत्री / धार्मिक नेता, सामुदायिक समूहों के लोग)
- ☐ समाचार पत्रों, टीवी, वेबसाइटों, सोशल मीडिया प्लेटफार्मों से जानकारी
- ☐ अन्य : ______________________

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E. सिगरेट का उपयोग

E1. एक औसत दिन में आप कितनी सिगरेट पीते हैं?

- ☐ कोई नहीं **[अगले सत्र F में जाएं]**
- ☐ दिन में एक से भी कम
- ☐ 1-10
- ☐ 11-20
- ☐ 21-30
- ☐ 31 या ज्यादा

E2. क्या आपने पिछले 12 महीनों में धूम्रपान रोकने में मदद लेने की कोशिश की है, चाहे अनौपचारिक रूप से किसी मित्र से या औपचारिक रूप से स्वास्थ्य पेशेवर से?

- ☐ नहीं
- ☐ हाँ

E3. अगर हां, तो, आप मदद के लिए कहां गए थे? आपके लिए लागू होने वाले **सभी** विकल्पों का चयन करें:

- ☐ मित्र
- ☐ परिवार
- ☐ जीपी
- ☐ परामर्शदाता
- ☐ वैकल्पिक उपचार (उदा। आयुर्वेद, हेंबंग, पारंपरिक चीनी चिकित्सा)
- ☐ समुदाय (जैसे मंत्री / धार्मिक नेता, सामुदायिक समूहों के लोग)
- ☐ समाचार पत्रों, टीवी, वेबसाइटों, सोशल मीडिया प्लेटफार्मों से जानकारी
- ☐ अन्य : ______________________________

F. मादक पदार्थ का उपयोग

F1. पिछले 12 महीनों में, क्या कभी आपने मनोरंजन के प्रयोजन से या खुद को हाई रखने के लिये नार्न-प्रिस्क्रिप्शन दवाओं का उपयोग किया है?

- ☐ नहीं **[अगले सत्र G में जाएं]**
- ☐ हां

F2. क्या आपने **पिछले 12 महीनों** में ड्रग्स लेने से खुद को रोकने में मदद लेने की कोशिश की है, चाहे अनौपचारिक रूप से किसी दोस्त से या औपचारिक रूप से स्वास्थ्य पेशेवर से?

- ☐ नहीं
- ☐ हाँ

F3. अगर हां, तो, आप मदद के लिए कहां गए थे? आपके लिए लागू होने वाले **सभी** विकल्पों का चयन करें:

- ☐ मित्र
- ☐ परिवार
- ☐ जीपी
- ☐ परामर्शदाता
- ☐ वैकल्पिक उपचार (उदा। आयुर्वेद, हेंबंग, पारंपरिक चीनी चिकित्सा)
- ☐ समुदाय (जैसे मंत्री / धार्मिक नेता, सामुदायिक समूहों के लोग)
- ☐ समाचार पत्रों, टीवी, वेबसाइटों, सोशल मीडिया प्लेटफार्मों से जानकारी
- ☐ अन्य : ______________________________

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G. ऑनलाइन सहायता सेवाओं के लिए प्राथमिकताएं

G1. क्या आपके पास निम्नलिखित तक पहुंच है (उन **सभी** विकल्पों का चयन करें जो आपके लिए लागू होते हैं):

- ☐ पर्याप्त डेटा वाला स्मार्टफोन
- ☐ पर्याप्त ब्रॉडबैंड इंटरनेट कनेक्शन / वाईफाई
- ☐ टेबलेट
- ☐ कैमरे के साथ लैपटॉप
- ☐ कैमरे के साथ पर्सनल कंप्यूटर
- ☐ इनमें से कोई नहीं
- ☐ अन्य (कृपया स्पष्ट करें):

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G2. ऑनलाइन सेवाओं का उपयोग करने के लिए आपको क्या आकर्षित करता है (आप पर लागू होने वाले **सभी** विकल्पों का चयन करें):

- ☐ सुविधा / अपने समय में कर सकते हैं
- ☐ समय पर सहयोग मिल सकता है
- ☐ अपनी खुद की जगह में गोपनीयता के साथ सहयोग प्राप्त कर सकते हैं
- ☐ सहयोग प्राप्त करने के लिए कोई यात्रा शामिल नहीं है
- ☐ अधिक लागत प्रभावी (जैसे यात्रा की कोई लागत नहीं)
- ☐ लचीला / अनुसूची करने के लिए आसान
- ☐ कम शर्मिंदा महसूस होने वाला (उदाहरण के लिए कम संभावना अन्य लोगों को ऑनलाइन सेवाओं के उपयोग के बारे में पता चलेगा)
- ☐ एक आरामदायक वातावरण में समर्थन प्राप्त करें
- ☐ इनमें से कोई नहीं
- ☐ अन्य (कृपया स्पष्ट करें):

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G3. क्या आपको निम्नलिखित समस्याएं हैं (उन **सभी** विकल्पों का चयन करें जो आपके लिए लागू होते हैं):

- ☐ इंटरनेट तक सीमित पहुंच
- ☐ खराब इंटरनेट कनेक्शन
- ☐ स्मार्टफोन / टैबलेट / लैपटॉप / पीसी तक सीमित पहुंच
- ☐ स्मार्टफोन / टैबलेट / लैपटॉप / पीसी का उपयोग करना नहीं जानते
- ☐ स्मार्टफोन / टैबलेट / लैपटॉप / पीसी का उपयोग करने में सहायता के लिए लोग (जैसे परिवार के सदस्य या दोस्त) आपके पास नहीं है
- ☐ ऑनलाइन सेवाओं का उपयोग करने के लिए एक निजी स्थान नहीं ढूंढ सकते
- ☐ ऑनलाइन सेवाओं का उपयोग करने के लिए समय नहीं मिलता
- ☐ आमने-सामने बातचीत को प्राथमिकता देते हैं
- ☐ ऑनलाइन सेवाओं का उपयोग करने वाले अन्य लोगों के बारे में चिंतित हैं
- ☐ इनमें से कोई नहीं
- ☐ अन्य (कृपया स्पष्ट करें):

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G4. आपकी निम्नलिखित ऑनलाइन सेवाओं का उपयोग करने की कितनी संभावना हैं:

	बहुत संभावना	संभावना	तटस्थ	कम संभावना	बहुत कम संभावना	पता नहीं
स्वयं सहायता संसाधन सूचना, उपकरण और दिशानिर्देश जो व्यक्तिगत रूप से भलाई में सुधार और प्रबंधन के लिए उपयोग किए जा सकते हैं						
ऑनलाइन कोचिंग व्यक्तिगत ऑनलाइन सहयोग और एक स्वास्थ्य पेशेवर द्वारा विकसित कोचिंग						
सहकर्मी-समर्थन मंच स्वास्थ्य अनुभवों को साझा करने और चर्चा करने के लिए ऑनलाइन सहायता समूह						
वेबिनार स्वास्थ्य पेशेवरों द्वारा प्रस्तुत मुफ्त ऑनलाइन स्वास्थ्य शिक्षा सेमिनार						
ऑनलाइन काउंसलिंग वीडियो कॉन्फ्रेंस (जैसे ज़ूम या स्काइप) के माध्यम से एक-एक कर परामर्श सेवाएं आयोजित की जाती हैं						

G5. आप कौन से सोशल मीडिया प्लेटफ़ॉर्म का उपयोग करते हैं (उन **सभी** विकल्पों का चयन करें जो आपके लिए लागू होते हैं):

- ☐ फेसबुक
- ☐ वीचैट
- ☐ इंस्टाग्राम
- ☐ व्हाट्सएप
- ☐ ककाओ टॉक
- ☐ टिक टॉक
- ☐ सिग्नल
- ☐ स्नैपचैट
- ☐ अन्य (कृपया स्पष्ट करें): ________________________

G6. क्या आपके पास इस सर्वेक्षण के बारे में हमें बताने के लिए आगे अधिक टिप्पणियां है?

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Asian Family Services
Together enriching lives

ए.फ.स. के पास मानसिक स्वास्थ्य, भलाई, पालन-पोषण और जुए के नुकसान जैसे कई उपयोगी साधन हैं। हमारे सभी संसाधन सांस्कृतिक और भाषाई रूप से उपयुक्त हैं और आपकी पसंदीदा भाषा में.

अगर आपको कोई परेशानी ना हो तो क्या हम अगले छह महीनों में आपके द्वारा उपयोग की जाने वाली सेवाओं के बारे में अधिक सवाल जवाब कर सकते है (यदि हां/ना)? इस प्रश्न के लिए हाँ कहना आप के लिए प्रतिबद्धता नहीं है, इसका सिर्फ यह अर्थ है कि हम आपसे संपर्क करके पूछ सकते हैं कि क्या आप फिर से भाग लेना चाहते हैं.

- ☐ नहीं मुझसे दोबारा संपर्क ना करें
- ☐ हां, आप मुझसे संपर्क करके पूछ सकते हैं कि क्या मैं फिर से मदद करना चाहता हूं

कृपया हमें नीचे अपनी संपर्क जानकारी प्रदान करें:

नाम ______________________

ईमेल ______________________

फोन नंबर ______________________

इस सर्वे को पूरा करने के लिए आपका बहुत-बहुत धन्यवाद।

आपके उत्तर हमारी ऑनलाइन सेवाओं और संसाधनों को विकसित करने में मदद करेंगे जो हमारे एशियाई समुदायों के लिए उपयुक्त हैं।

यदि आपको किसी से बात करने की आवश्यकता है, तो अपॉइंटमेंट बुक करने के लिए कृपया एशियाई हेल्पलाइन (0800 862 342) पर कॉल करें।

✂ -

अब आप इस ड्रा में भाग लेने योग्य हैं।

$500, $300 और $200 सुपरमार्केट के ये तीन वाउचर हैं जो निश्चत रुप से ड्रा के माध्यम से जीते जाएंगे I. विजेताओं की घोषणा मई में एएफएस और अपोलो मेडिकल सेंटर वेबसाइटों पर की जाएगी।

ड्रा में भाग लेने के लिए, कृपया नीचे अपना संपर्क विवरण दें। आपका विवरण केवल पुरुस्कार के प्रयोजनों के लिए उपयोग किया जाएगा और इसे आपके सर्वे के उत्तर से जोडा नहीं जाएगा।

नाम ______________________

ईमेल ______________________

फोन नंबर ______________________

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Appendix 5 A guide for Asian people to manage addictions and emotional distress: English

A GUIDE FOR

Asian people to manage addictions and emotional distress

Asian Family Services

Together enriching lives

Acknowledgements

This booklet was developed as part of a research project funded by the Ministry of Health Gambling Innovation Research and Evaluation 2018/19. Thanks are extended to the Health Promotion Agency and to the many people who helped in the development and production of this booklet.

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What we provide?

3.4 million New Zealanders gamble;
among them, one in five gamble weekly or more.

One in four New Zealand drinkers
have drunk hazardously which could have hurt themselves or others.

One in eight New Zealand adults
smoke on a daily basis.

Around one in two New Zealanders
will experience poor mental health at some points in their lives.

Smoking, harmful gambling, alcohol drinking, substance use and mental health issues have caused great concerns within Asian communities in New Zealand. However, many people who have these issues can't see the problem for themselves, and don't deal with them until their problems become quite serious.

Research indicated that harmful gambling is to some extent associated with hazardous drinking, tobacco smoking and substance use. Moreover, research revealed that people who are addicted to these issues are also likely to suffer from emotional distress and mental health issues.

What we provide?

This guide provides a range of useful information and advice to help Asian people, including:

- Identifying if they may be experiencing difficulties in managing issues associated with gambling, smoking, alcohol, drugs, and emotional distress;
- Learning some strategies and tools to manage these issues;
- Obtaining available professional support services.

You can also download this guide from the Asian Family Services' website:
www.asianfamilyservices.nz

Gambling

Is your gambling harmful?

Tick the box if you have experienced any of the following, either now or in the past:

- trying to win back money you have lost gambling
- hiding your gambling from people who are important to you
- feeling guilty about your gambling
- losing track of time when gambling
- spending more money on gambling than you had planned
- gambling when feeling stressed or lonely
- feeling regret after gambling
- borrowing money to finance gambling
- losing interest in other activities.

If you have one or more ticks above, or you are concerned about your gambling, you can talk to someone in confidence who can support you and help you understand more about your gambling behaviour.

You can call the Asian Helpline on 0800 862 342 for free, confidential and professional counselling and support services in seven Asian languages (Cantonese, Hindi, Japanese, Korean, Mandarin, Thai and Vietnamese) plus English.

Tips on preventing harms associated with gambling

- Be honest with yourself
- Be honest with your friends and family
- Track your gambling activities

Describe and record your gambling details, like how many times per week, where, how much cash spent, net profit/loss and whom you gambled with.

Identify and record your main reason for gambling each time you gamble: Did a friend drag you into gambling? You gambled out of boredom or loneliness? Out of drunkenness, or because of too much stress?

Plan your finances in advance

Set an amount that you can afford to spend on gambling. When gambling, take your set amount in cash and leave bank cards at home to avoid impulsive gambling. Let someone you trust keep and protect your credit and Eftpos cards.

Engage yourself in pleasurable and healthy activities

List the activities that you like doing or want to do. Keep yourself occupied with the activities listed.

Keep away from places where you gamble

Under New Zealand law you can exclude yourself from licensed gambling venues, which can be a useful way of breaking gambling habits. You can approach the venue staff for assistance.

A local counsellor can support you with the self-exclusion process. Call the Asian Helpline on 0800 862 342 for further information.

Block Internet access to gambling sites

Software programmes like Safe Eyes, Secure Web, and GamBlock can be installed to block certain sites, restrict access times, and block whole categories of sites. There are also programmes that will monitor and report all activities from a computer.

Get support from others

Family and friends can help and monitor the planning and execution of a non-gambling plan. Engage with a trained counsellor who can walk alongside with you.

You can help if you are concerned about someone's harmful gambling

Talk to them

Initiate a conversation with the person as they may feel embarrassed or ashamed, or they may not think they should change.

Help with financial management

Help them manage their finance and look after their credit and Eftpos cards.

Set up automatic payments for bills and give them only what they need for essentials.

Find a budget adviser if you need help. For example, you can go to your local Citizens Advice Bureau (CAB) for budgeting advice.

Discourage them from gambling

Under New Zealand law, a venue can exclude a person with a gambling problem, or someone can choose to exclude themselves from a venue or multiple venues. To do this, you need to identify the person to venue staff as having a gambling problem.

The venue operator must then, by law, exclude them from the venue. If a person has been excluded from a venue, they, and the venue operator can be fined if they re-enter the gambling area.

Help is available for both of you.
Call 0800 862 342 to ask for professional help.

A local counsellor can help support you with the exclusion process.

Call the Asian Helpline on **0800 862 342**
for further information.

Block Internet access to gambling sites

Software programmes like Safe Eyes, Secure Web, and GamBlock can be installed to block certain sites, restrict access times, and block whole categories of sites.

Divert them to other pleasurable and meaningful activities

Try to guide and divert the person to other activities they enjoy, such as social gatherings, travel or outdoor activities that keep their mind off gambling.

As an affected family member or a friend, if your life has been negatively affected by gambling, you can call the Asian Helpline on **0800 862 342** for professional help.

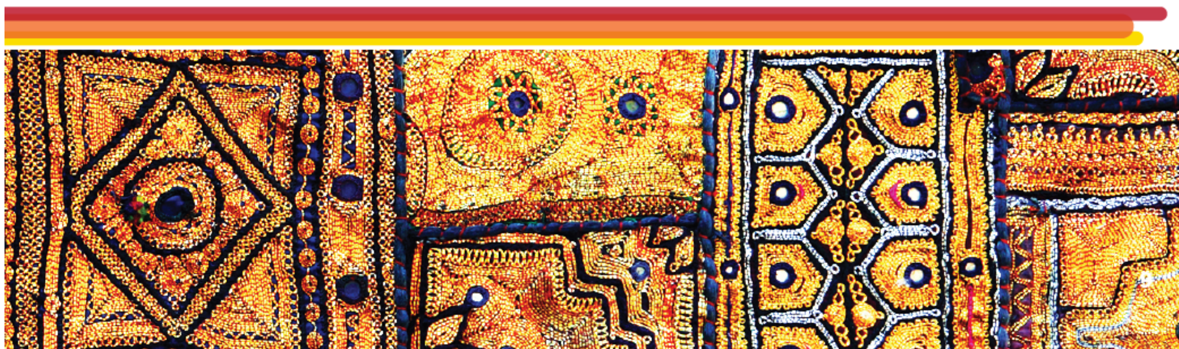
Useful contacts and information

ASIAN HELPLINE: **0800 862 342** (Mon– Fri, 9am to 8pm)

AUCKLAND OFFICE: Level 1, 128 Khyber Pass Rd, Grafton, Auckland
WELLINGTON OFFICE: Level 3, 5-7 Vivian Street, Wellington
OFFICE HOURS: Mon – Fri, 9am-5pm

WEBSITE: **www.asianfamilyservices.nz**
EMAIL: **help@asianfamilyservices.nz**

Asian Family Services counsellors are always ready to help you.



Alcohol and Drugs

Is your alcohol or drug use harmful?

Check whether you are experiencing or have experienced any of the following:

- drink/use more than intended
  (e.g. vomiting or experiencing a hangover following excessive drinking)
- have black outs or lose consciousness
- have cravings for alcohol or other drugs
- have had previous failed attempts to stop or manage alcohol or other drug use
- experience significant changes in mood and/or behaviour
- experience physical sickness or emotional difficulties
- neglect responsibilities
  (e.g. skipping school, missing work, neglecting household chores)
- decreased productivity
- have had accidents or near-misses
- have driven under the influence of alcohol or other drugs
- have had financial problems
- experienced deteriorating relationships at work and with family and friends
- have been doing things you normally wouldn't do
  (such as illegal activities like stealing).

While you may not be able to immediately identify a problem with alcohol or other drug use, your pattern of use may be hazardous such that it puts you at risk of developing one or more of these problems in the future. If you are concerned about your alcohol and/or other drug use, you can talk to someone in confidence who can support you and help you understand more about your conditions.

Tips on preventing harms associated with alcohol and/or other drug use

- Some people drink when they are feeling hungry, angry, lonely or tired. Recognise these feelings when they occur and look for effective ways to manage them.
- When you are feeling stressed, take a deep breath, take a step back and see what options are available for you.
- If your friends are influencing your use, stay away from them and get new friends.
- If you find it hard to control your use, consider seeking professional help.

You can help if you are concerned about someone's harmful drinking or drug use

You can help a person to re-consider their drinking or drug use. The following are tips for an effective conversation:

- Choose a time and place where the other person is relaxed and not intoxicated.
- It is better to ask a question than to make a statement. In this way you will be less likely to appear critical or judgmental. Tell the person that you are concerned about their alcohol or drug use because you care about them. For example, you can say "You look stressed/unwell, would you like to talk about it? Or can I help with anything?" instead of "you look like you have used drugs again."
- Remember, you cannot fix another person's problem. Sometimes you need to seek professional help. You can be a friend or a 'mate', provide encouragement in supporting them to make positive changes to their lifestyle.
- Your support as a friend may not be welcomed and you may not always feel appreciated.
- You could encourage the other person to contact the agencies listed below for professional support.

Free and confidential services are available.
Alcohol Drug Helpline on 0800 787 797 (24 hours, 7 days a week) or
Asian Helpline on 0800 862 342 (Mon-Fri, 9am-8pm)
will be able to help you.

Useful contacts and information

ALCOHOL DRUG HELPLINE
PHONE: **0800 787 797**
WEBSITE: **www.alcoholdrughelp.org.nz**

CARENZ
WEBSITE: **www.carenz.co.nz**

- **Counties Manukau Community Services**
  521 Great South Road, Manukau, Auckland 2025
  PHONE: **0800 682 468**
  EMAIL: **auckland@carenz.co.nz**
- **Waikato Community Services**
  PHONE: **0800 499 469**
  EMAIL: **waikato@carenz.co.nz**
  Satellite services available in Matamata, Putaruru and Tokoroa
- **Wellington Community Services**
  Ground Level, 138 The Terrace
  PHONE: **0800 385 151**
  EMAIL: **wellington@carenz.co.nz**
- **LOWER HUTT COMMUNITY SERVICES**
  40-44 Bloomfield Terrace, Lower Hutt 5010
- **Kapiti Coast Community Services**
  Coastlands Shoppingtown, Paraparaumu

DRUG HELP
0800 METH HELP (**0800 6384 4357**)
for a meth or P related issue or problem

Useful contacts and information

FOR AUCKLAND REGION ONLY

COMMUNITY ALCOHOL AND DRUG SERVICES (CADS)

HOURS: 9am-4.30pm Mon-Fri

PHONE: **09 845 1818** (English) **09 442 3232** (Chinese and Korean only)

WEBSITE: **www.cads.org.nz**

MEDICAL DETOXIFICATION SERVICES FROM CADS

Pitman House, 50 Carrington Rd, Pt Chevalier Auckland 1025

APPOINTMENTS: Mon-Fri 9am-4.30pm

DROP-IN CLINIC: Mon-Fri 10am-1pm (no appointment necessary)

PHONE: **09 845 1818**

NZ DRUG FOUNDATION (information and advice)

WEBSITE: **www.drugfoundation.org.nz**

Smoking

Is your smoking harmful?

There are more than 5,000 chemical compounds found in cigarette smoke and hundreds of them are harmful to human health. While vaping is less harmful than smoking, it is unlikely to be totally harm free. Scientists are still uncertain of the long-term health risks associated with vaping.

How to manage your smoking?

Change routines, practise 4Ds:

DELAY – Delay acting on the urge to smoke. Don't open a pack or light a cigarette. After a few minutes, the urge to smoke will pass.

DEEP BREATH – Take a long slow breath in, and breathe out slowly again. Repeat three times.

DRINK WATER – Sip it slowly, holding it in your mouth a little longer to savour the taste.

DO SOMETHING ELSE THAT IS ENJOYABLE AND HEALTHY – Take your mind off smoking by taking action – put on some music, go for a walk, ring a friend and keep your hands busy.

Nicotine Replacement Therapy

Nicotine Replacement Therapy (NRT) uses nicotine patches, gum or lozenges to reduce withdrawal symptoms and can double your chances of stopping smoking. They are safe to use, and work by replacing some of the nicotine you usually get from cigarettes or tobacco.

You can get NRT from the following places:

- Your local stop smoking service
- Quitline, online or by phone
- Via a prescription from your GP or primary health care provider
- A pharmacy
- The supermarket

There will be a $5 dispensing fee if you access it via Quitline, your GP or pharmacist.

You can help if you are concerned about someone else's smoking behaviour

Because smoking is addictive it is important to support people who want to quit smoking.

- Remind them you are there to support them.
- Remind them that they are doing it out of love for their loved ones and the environment.
- If you are a smoker, consider quitting with them. Quitting together with family and friends can make the journey a lot easier for both of you.
- Don't nag! Be positive and remind people of the many reasons to not smoke – you will have more money, your taste buds will come alive, you will breathe easier, you'll smell nicer!
- Tell them about stop smoking services that can help.
- Remove things that might prompt smoking (like ashtrays and lighters) and keep cigarette packs out of sight.
- Go to places where no one smokes, like smoke-free parks and sports grounds. It is also good to stay active, as boredom can be a trigger for smoking.
- Remind them of their reasons for quitting.
- Tell them having slip-ups is normal. Stopping smoking is challenging and usually takes several attempts. The important thing is to keep trying.

Useful contacts and information

QUITLINE (24/7)
PHONE: **0800 778 778**
TEXT: **4006**
WEBSITE: **www.quit.org.nz**

ASIAN SMOKE-FREE COMMUNITIES
PHONE: **09 4151091**

READY, STEADY, QUIT
PHONE: **0800 500 601**
EMAIL: **info@readysteadyquit.org.nz**

Emotional Distress

Are you experiencing emotional distress?

Check how well you are doing emotionally, are you:

- Eating too much or too little
- Sleeping too much or too little
- Having low or no energy
- Having unexplained aches and pains, such as constant stomachaches or headaches
- Smoking excessively, drinking, gambling or using drugs, including prescription medications
- Having difficulty readjusting to home or work life
- Pulling away from people and things
- Feeling helpless or hopeless
- Worrying a lot of the time; feeling guilty but not sure why
- Thinking of hurting or killing yourself or someone else.

Most symptoms are temporary and will resolve within a certain period of time. However, if you have some of these symptoms every day or nearly every day for more than two weeks, it is likely that you are emotionally distressed. If untreated, it may influence your life, and your relationships with families and friends.

Emotional Distress

Tips on managing your emotional distress

- Talk to someone you trust about it
- Take a walk
- Get your hands dirty by doing some gardening or engage in arts
- Listen to pleasant music
- Make time to connect with family and friends
- Maintain a balanced diet
- Engage in enjoyable activities
- List out positive self-talk statements

You can help someone with emotional distress

- Listen to the person. Let the individual know that you care.
- Be accepting and non-judgmental. Help the person determine what the problem might be, without minimising their feelings or judging them.
- Acknowledge the person is hurting and has sought help from you. For example, "I'm glad you told me how you're feeling. I'm willing to listen or help you find professional support who is trained to assist individuals with similar concerns."
- Know your limits as a support person and understand there are professional support services that you can reach out to for information and support for the person. While talking to the individual, you may find that you are unable to provide adequate assistance or do not feel comfortable trying to help someone cope with his or her problems. If this is the case, it is important that you indicate in a gentle but direct manner that professional assistance is free and available.
- Use the professional resources available to you. You can find valuable information online or through mental health organisations.

Useful contacts and information

Asian Family Services offers telephone and face-to-face counselling services in 7 Asian languages plus English

ASIAN HELPLINE: **0800 862 342** (nationwide, Mon-Fri, 9am-8pm)

LIFELINE: **0800 543 354**

SUICIDE CRISIS HELPLINE: **0508 828 865** (0508 TAUTOKO)
12 noon to 12 midnight (This helpline targets those in distress, or those who are concerned about the wellbeing of someone else).

Appendix 6 Webinar series promotional poster: Chinese

维护身心健康系列讲座

亚裔家庭服务中心将通过Zoom举办三场线上讲座。

讲座将涵盖以下主题：

讲座1：关注身心健康
讲座2：如何帮助亲友的精神健康及上瘾问题
讲座3：如何预防和减少赌博危害

所有线上讲座将用中文进行并且完全免费。

您的Zoom参与信息将被自动隐蔽，您将以匿名身份参加。

线上讲座日期：

讲座1：6月2日（星期三）晚上7-8 点

讲座2：6月9日（星期三）晚上7-8 点

讲座3：6月16日（星期三）晚上7-8 点

您可以点击以下链接参与：
bit.ly/afswebinarCH

或者通过Zoom程序搜索会议号码：
867 8304 1432 参与

Alex Wang

Appendix 7 Webinar series promotional poster: Korean

정신건강증진: 웨비나 시리즈

아시안 패밀리 서비스는 줌을 통한 온라인 웨비나를 3회에 걸쳐 실행합니다.

온라인 웨비나는 다음의 주제로 진행됩니다:

- 웨비나 1 - 건강과 웰빙
- 웨비나 2 - 가족 심리교육
- 웨비나 3 - 도박의 피해에 대한 방지와 최소화

모든 웨비나는 무료이며, 한국어로 진행됩니다.

모든 웨비나는 익명으로 참여하시게 됩니다.

웨비나 날짜:

웨비나 1: 6월 3일 목요일, 7-8pm

웨비나 2: 6월 10일 목요일, 7-8pm

웨비나 3: 6월 17일 목요일, 7-8pm

링크를 누르시면 누구라도 참여하실 수 있습니다:
bit.ly/afswebinarKR

또는, 줌 앱을 사용하시는 분은 아이디: 863 8285 9357를 통해 참여하실 수 있습니다.

김임수

Appendix 8 Webinar series promotional poster: English

Maintaining Wellness: Webinar Series

Asian Family Services will be holding three online webinars via Zoom. Our webinars will cover the following:

Webinar 1 - Health and wellness
Webinar 2 - Family psychoeducation
Webinar 3 - Preventing and minimising gambling harm

All webinars are free of charge and will be delivered in English.

You will remain anonymous to other attendees for all webinars.

English

Webinar 1 – Wednesday 21 July at 7–8pm
Webinar 2 – Wednesday 28 July at 7–8pm
Webinar 3 – Wednesday 04 August at 7–8pm

Click the link to join: shorturl.at/gqNS9
Or enter the Zoom Webinar ID:
821 3817 2633

Presented by: Aashini Jutson

Appendix 9 Webinar poll questions

Webinar 1 Health and Wellness

Polling question 1

How well do you understand the impact of stress on cognitive, physical, emotional and behavioural symptoms?

No understanding				Moderate understanding					Excellent understanding
1	2	3	4	5	6	7	8	9	0

Polling question 2

Do you find the techniques introduced in this webinar help you to manage stress you are experiencing?

Not helpful at all				Somewhat helpful					Extremely helpful
1	2	3	4	5	6	7	8	9	0

Polling question 3

Has your knowledge on available mental health support services for Asian people increased after this webinar?

No increase in knowledge				Some increase in knowledge					A lot of increase in knowledge
1	2	3	4	5	6	7	8	9	0

Webinar 2 Family psychoeducation

Polling question 1

How harmful do you consider the following gambling activities:

(a) Gambling machines (or Pokies)

Not harmful				Somewhat harmful					Extremely harmful
1	2	3	4	5	6	7	8	9	0

(b) Lottery

Not harmful				Somewhat harmful					Extremely harmful
1	2	3	4	5	6	7	8	9	0

(c) Casino gambling

Not harmful				Somewhat harmful					Extremely harmful
1	2	3	4	5	6	7	8	9	0

(d) Sports betting

Not harmful				Somewhat harmful					Extremely harmful
1	2	3	4	5	6	7	8	9	0

(e) Online gambling

Not harmful				Somewhat harmful					Extremely harmful
1	2	3	4	5	6	7	8	9	0

Polling question 2

Do you find the warning signs of harmful gambling introduced in this webinar useful in helping people identify gambling problems in the family?

Not useful at all				Somewhat useful					Extremely useful
1	2	3	4	5	6	7	8	9	0

Polling question 3

If you are concerned about someone's gambling, how likely would you apply the strategies introduced in this webinar to help yourself and your loved ones?

Not likely at all				Somewhat likely					Extremely likely
1	2	3	4	5	6	7	8	9	0

Webinar 3 Preventing and Minimising Gambling Harm

Polling question 1

How helpful was the 'Tree Model' in helping you understand the struggles of migration as one of the causes of gambling?

Not helpful at all				Somewhat helpful					Extremely helpful
1	2	3	4	5	6	7	8	9	0

Polling question 2

How well do you understand the emotional, psychological, financial and social impact of problem gambling?

No understanding				Moderate understanding					Excellent understanding
1	2	3	4	5	6	7	8	9	0

Polling question 3

Has your knowledge on how to prevent and minimise gambling harm increased after this webinar?

No increase in knowledge				Some increase in knowledge					A lot of increase in knowledge
1	2	3	4	5	6	7	8	9	0

Appendix 10 Webinar poll results: average rating (1-10) of poll responses (m) and standard deviation (sd)

	Chinese webinars		Korean webinars		English webinars	
	m	sd	m	sd	m	sd
Webinar 1 Health and Wellness						
Q1. How well do you understand the impact of stress on cognitive, physical, emotional and behavioural symptoms?	7.54	2.22	9.00	1.55	--	--
Q2. Do you find the techniques introduced in this webinar help you to manage stress you are experiencing?	8.38	1.61	9.50	1.00	8.67	0.58
Q3. Has your knowledge on available mental health support services for Asian people increased after this webinar?	8.15	1.91	9.50	0.58	9.00	1.00
Webinar 2 Family psychoeducation						
Q1. How harmful do you consider the following gambling activities: *(a) Gambling machines (or Pokies)*	8.45	1.75	7.70	2.21	10.00	0.00
(b) Lottery	7.91	2.21	9.60	0.52	10.00	0.00
(c) Casino gambling	4.55	3.08	9.20	2.20	10.00	0.00
(d) Sports betting	6.45	2.38	9.70	0.95	10.00	0.00
(e) Online gambling	7.36	1.91	10.00	0.00	10.00	0.00
Q2. Do you find the warning signs of harmful gambling introduced in this webinar useful in helping people identify gambling problems in the family?	8.00	1.79	7.70	2.50	--	--
Q3. If you are concerned about someone's gambling, how likely would you apply the strategies introduced in this webinar to help yourself and your loved ones?	7.91	1.30	8.30	2.00	8.00	0.00
Webinar 3 Preventing and Minimising Gambling Harm						
Q1. How helpful was the 'Tree Model' in helping you understand the struggles of migration as one of the causes of gambling?	8.43	1.90	10.00	0.00	9.00	0.00
Q2. How well do you understand the emotional, psychological, financial and social impact of problem gambling?	8.17	1.94	10.00	0.00	8.00	0.00
Q3. Has your knowledge on how to prevent and minimise gambling harm increased after this webinar?	7.50	1.64	9.00	1.00	10.00	0.00

--No poll responses