How the wellbeing of addiction practitioners is affected by their professional practice.

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2018

Abstract

Addiction practitioners in New Zealand work alongside those who are experiencing a range of addictions, as well as those who care for them, to assist in making recovery for clients possible. While the impact of professional practice on the wellbeing of healthcare professionals has been well researched, there has been insufficient attention paid to roles which are addiction specific.

This research investigates how the wellbeing of addiction practitioners may be affected by their professional practice, using Te Whare Tapa Wha as the framework for understanding individual health and wellbeing. The focus of this study is to understand how addiction practitioners consider their wellbeing has changed since working as a practitioner. It sets out to do this by applying the Te Whare Tapa Wha model of health developed by Durie (1984) and using the indicators developed by Durie and Kingi (1997) to identify data related to each dimension of Te Whare Tapa Wha. This research uses a questionnaire method, administering twenty-two questions to a sample of registered addiction practitioners in New Zealand. A pragmatic stance was selected for this study.

The findings indicate that addiction practitioners in this sample have experienced changes in their health since becoming employed as an addiction practitioner, in relation to the dimensions of Te Whare Tapa Wha. Within this small sample, responses appeared to indicate that length of service may impact on practitioner wellbeing in a variety of ways, which is an area for further research. The qualitative findings of this research illustrated the quantitative responses. The low response rate for the questionnaire leads to a high non-response bias, which is noted as a limitation.

Recommendations from this research include the development of an addiction practitioner's wellness monitoring tool, addiction practitioner specific education and development opportunities, and the implementation of wellbeing plans for practitioners even before professional practice commences. Additional recommendations include the increased organisational promotion of employee assistance/employee wellness programmes, further exploration of the impact of employment in addiction services on those who are attempting to sustain their own recovery from addiction and assessing the effectiveness of clinical supervision on the wellbeing of addiction practitioners.

Dedication

E te Atua o te Moana-nui-a-Kiwa,
me ēnei motu, o te iwi Māori, te iwi Pākehā, me rātou katoa e noho nei i tēnei wāhi.
Ka whakamoemiti, ka whakawhetai ki a koe mō tēnei whenua o mātou;
mō ngā mea pai katoa kua whiwhi tahi nei mātou.
Whakanuia tō mātou aroha tētahi ki tētahi, whakakahangia tō mātou whai i te tika
kia kotahi ai mātou i runga i te whakaaro kotahi.
Kua hanga matou e koe hei toto kotahi;
i raro i tēnei whakaaro kotahi. Āmine.

God of the southern sea
and of these islands,
of Māori, Pākehā, and of all who dwell in our land;
we give you thanks and praise for our country,
and for what we have achieved together.
Increase our trust in one another; strengthen our quest for justice,
and bring us to unity and a common purpose.
You have made us of one blood;
make us also of one mind.
Amen.

'Prayer for our Country'. He Karakia Mihinare o Aotearoa.

Acknowledgments

George, Gertie, Isabel and Logan, thank you for the lives you lived. Thank you for the values you instilled in your children. Thank you for all the things you did which were not truly appreciated by me until I did not have the chance to tell you. Most of all, thank you for my parents.

Dad, you're my hero. Thank you for always believing in me, being there for me, and teaching me the value of hard work. Thank you for the upbringing we had, for the adventures and the laughter. Thank you for your advice and guidance over the years, which has never put me wrong.

Mum, you are the heart of the family. Thank you for your care for us. Your dedication to your children is relentless, and we are lucky to have a lioness for a mother! Thank you for never giving up, and for the sacrifices you have made for your family.

Joe, thanks for being my best mate. I'm not sure you'll ever understand how much your quiet support has meant to me over the years. Your life is such a gift to me, and you still can't put a foot wrong in my books, little brother.

Sam, I love you, and I am so proud of everything you have achieved and overcome. You'll always be a hero to your little sister.

Kyle, thank you for your unflinching belief in me. Thank you for encouraging me. Your humour, love and support have seen me through the highs and lows of the research journey. Thank you for sharing your life with me. I can't wait to be your wife!

Colin, Jan and Ngaire, thank you for sharing your family with me. Thank you for being my home away from home, and for the sense of belonging I have when I am with you. I appreciate everything you have done for Kyle and I.

Maynard Gilgen, E te tōtara, Kei taku whatumanawa e rere tenei mihi aroha mōu. Nā tō manaakitanga taku kaha i puta kia hikoi ai i te Ao Māori. Nā reira, e tika ana te kōrero E tū ana au i runga i ngā pokohiwi o te totara kia titiro ai te pae tawhiti.

Dr. Stephanie Kelly and Cynthia Young, thank you for giving me your time, knowledge and encouragement throughout the process of this research. Your dedication to my success has been truly appreciated. Stephanie, I will not forget the weekends, evenings and face to face hours you have sacrificed supporting this research.

Marko Kljakovic, thank you for being living proof that there are GP's in the world who will take the time to explore the life behind the symptoms. You have been a role model to me without knowing it, and your life has made a significant difference to mine.

Abbie Ranui, you are the trailblazer who carved the path for the rest of us. Your easy way of supporting and encouraging made this work seem achievable, and your practical support kept me sane! I value you, and the contribution you make to the mental health and addiction workforce. New Zealand is lucky to have you!

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Glossary of terms

Aroha	To love or sympathise
Hauora	Māori philosophy of wellbeing
Mana	Influence and force in a person, place or object
Mauri	Life force and vital essence
Pono	To be true, valid, honest, genuine, sincere
Tika	To be fair, accurate, appropriate, lawful, proper, valid
Taha hinengaro	Mental/emotional health
Taha tinana	Physical health
Taha wairua	Spiritual health
Taha whānau	Social/family health
Tangata	Person, people
Tangata Whaiora	A person seeking health
Tangata Whenua	People of the land/those who have authority
Tapu	Sacred, restricted, set apart, forbidden, under protection
Te Whare Tapa Wha	Māori model of holistic wellbeing
Wairua/Wairuatanga	Spirituality
Whānau	Extended family

Translations from Te Aka Māori-English, English-Māori Dictionary and Index. (2011). Pearson publishers.

Chapter One
Introduction

This chapter provides an overview of the aim of this research, as well as a rationale for research exploring the wellbeing of addiction practitioners in New Zealand. Following this, the rationale and significance of investigating this issue will be described. An overview of the methodology and research design will also be provided.

This research explores changes in the wellbeing of a small sample of addiction practitioners since beginning their professional practice, in relation to the dimensions of wellbeing which are represented in the Te Whare Tapa Whā model of health (Durie, 1984). The aim of this research is to better understand the ways that addiction practitioners are affected by their work, through the application of the Te Whare Tapa Whā model of health. The research objective is to provide an evidence base to inform employers and agencies to support addiction practitioners with strategies to cope with the potential health and wellbeing related consequences of the work.

An awareness of the impact of employment as an addiction practitioner on personal wellbeing may contribute to opportunities for professional development and other forms of support, such as encouraging practitioners to seek supervision when personal health issues present, and ensuring practitioners are supported to address these issues.

The importance of this research is in its contribution to an evidence base to support effective preparation and support of practitioners in relation to the identified effects of their practice in addiction services. The importance of research that specifically focuses on the wellbeing of addiction practitioners is supported by the limited current information in this field. Parallel research in general nursing does exist, however this lacks the specificity required to identify the impact of employment on the wellbeing of addiction practitioners specifically.

New Zealanders are experiencing increasing rates of addiction (Ministry of Health, 2016), so the addiction sector requires an evidence base to better understand the needs and experiences of the addiction workforce to support the provision of quality

care. Interest in the impact of employment in addiction services on personal health was ignited during the researcher's time working as a registered addiction practitioner. Addiction practitioners would often speak about feeling overworked, stressed and undervalued.

At the same time, practitioners would share the sense of meaning they gleaned from their work. This sense of meaning often did not provide the level of adhesive required to maintain a long-term career as an addiction practitioner. The researcher became increasingly curious about the impact of the role of an addiction practitioner on an individual's mental, physical, spiritual and social health.

The researcher acknowledged that her own perception of what constitutes health and wellbeing was multidimensional, and not aligned with purely medical models of explaining health. This multidimensional perception of health and wellbeing has been reflected in New Zealand models of health that acknowledge mental, spiritual and social wellbeing alongside the consideration of physical wellbeing.

This study explores the impact of employment as an addiction practitioner on the social, spiritual, emotional and physical wellbeing of the practitioner. It does this by applying Te Whare Tapa Whā to a research design that involves a questionnaire administered to a sample of practicing addiction practitioners. Te Whare Tapa Whā forms the theoretical framework and the methodological approach for this research.

Te Whare Tapa Whā also contributed to the development of indicators for multidimensional wellbeing, which informed the development of the research questions. Te Whare Tapa Whā is applied in recognition of its prolific application in health and social services throughout New Zealand.

Chapter Two introduces Te Whare Tapa Whā (Durie, 1984) as the framework which informs this research, and discusses its purpose and aims. This chapter also provides an overview of the social and political context of the introduction and development of Te Whare Tapa Wha.

Chapter Three reviews the literature which has been conducted in the areas of workplace health and wellbeing, followed by a review of research which applies Te Whare Tapa Wha. This literature will be organised according to the dimensions of Te Whare Tapa Wha.

Chapter Four outlines and discusses the methodology which informs the research design. It applies Te Whare Tapa Whā methodologically and from a pragmatic stance. A discussion of the methods used throughout the research process will be provided.

Chapter Four also provides an insight of how the research journey impacted the researcher, exploring questions and challenges that presented themselves throughout the process of research.

Chapter Five outlines the quantitative and qualitative findings of this study. It does this by summarising the findings for the questionnaire using frequency and comparative analysis tables, and thematic analysis, followed by a brief written summary of the data collected in each question.

Chapter Six discusses the findings. The pillars of Te Whare Tapa Whā are applied as a framework for understanding individual physical, mental, emotional and spiritual wellbeing in their component parts from the perspectives of addiction practitioners.

Chapter Seven outlines some of the implications, limitations, and recommendations related to this study.

Chapter Eight provides a conclusion of this research, outlining what the study set out to achieve, the importance of this research, and how Te Whare Tapa Whā was applied as a theoretical framework.

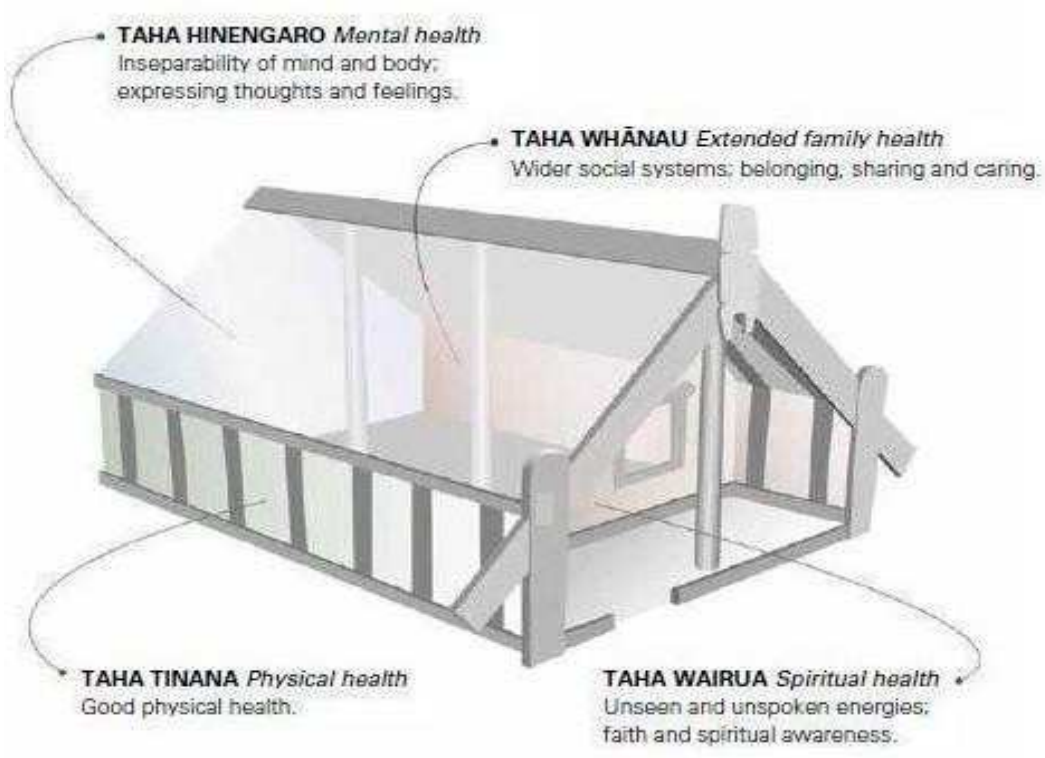
Chapter Two
Theoretical framework

This section introduces and outlines Te Whare Tapa Whā (Durie, 1984) as the framework which informs this research. An outline of Te Whare Tapa Whā is provided, including a discussion of its purpose and aims. This section will follow with an overview of the social and political context of the introduction and development of Te Whare Tapa Whā. Consideration will be given to the significance of the Treaty of Waitangi in this context. This chapter will also outline the dimensions within Te Whare Tapa Whā and their relationships to one another. The application and use of Te Whare Tapa Whā in the wider New Zealand health and social services context since its introduction, up to the current context will be outlined.

The section will finish with a discussion of the significance of Te Whare Tapa Whā by outlining the place of Te Whare Tapa Whā in this current research, from consideration of the research aim and question, through to how it informs the methodology, the choices of what and how to measure in the research design, and the discussion of the research findings. This theoretical framework will inform the next chapter which critically reviews the research which has drawn on and applied Te Whare Tapa Whā to a range of contexts in health, education and social services.

Te Whare Tapa Whā is a health and wellness model developed by Durie to consider individual wellbeing for Maori in New Zealand (Durie, 1984). Te Whare Tapa Whā is described using a metaphor of a meeting house with four walls, where the four walls symbolise the four dimensions of wellbeing, which are identified as: mental, physical, social, and spiritual, as identified by Durie (1984). According to Durie (1984), individual wellbeing for Maori should consider all four dimensions being in balance. The dimensions of Te Whare Tapa Whā are represented visually in the in the figure below.

Figure 1: The Te Whare Tapa Whā Health model.



Source: https://teara.govt.nz/en/diagram/31387/maori-health-te-whare-tapa-wha-model.

Purpose and aim

Te Whare Tapa Whā was developed by Durie (1984) to challenge dominant models of how to consider and treat health and wellbeing for Maori, which were identified as not serving the needs of Maori (Durie, 1984; Murchie, 1984). The model was developed in response to Rapuora, a piece of research undertaken from 1978 to 1980 by the Maori Women's Welfare League (Murchie, 1984) that uncovered the issues and barriers Maori were experiencing in their personal health. Murchie aimed to explore the dimensions of health and wellbeing practice in New Zealand that were not serving the needs of Maori (Murchie, 1984.). To explore these dimensions, Murchie designed a survey which aimed to identify the difficulties and obstacles that Maori were encountering in health.

Findings noted that the obstacles that Maori were experiencing in health had contributed to increased disconnection with health services, ultimately resulting in poorer health outcomes overall for Maori. A key theme that emerged from this

research was the need for health services to recognise the concept of health beyond a purely medical model.

According to Durie (1984) and Murchie (1984), elements of Maori identity were intrinsically linked to Maori wellbeing, and it was argued, these could not be considered separately from physical health. These elements were described as cultural, social, emotional, and spiritual. These elements, when considered alongside physical wellbeing, could give a more reflective view of Maori wellbeing.

Individual measures of health

There are a range of definitions of individual health internationally, some of which focus on the absence of physical symptoms (Brandt, 1997; Findley, 1992; Helman, 1994), and some of which consider health more broadly to include mental and emotional dimensions (Durie, 1984; Kleinman, 1995; Shepard, 1997). Because of the broad range of definitions regarding what constitutes individual health (Corbin, 2001), there is agreement throughout the literature developed over the past two decades that definitions of health should be multidimensional (Benzer, 2015; Durie, 1984; Roscoe, 2009; Stevenson, 2000).

Benzer (2015) argues that the specific dimensions that are included in any definition of health are considerably less important than the recognition that there are multiple dimensions that require recognition, and that these dimensions interact with each other. The World Health Organization defines individual health as “a state of complete physical, mental and social well-being and not merely the absence of disease” (WHO, 2001). This definition recognizes that health needs to be considered holistically. The World Health Organization definition of individual health aligns with the dimensions of wellbeing illustrated by Te Whare Tapa Wha, in terms of the recognition that any definition of health needs to consider dimensions outside a purely physical scope.

Te Whare Tapa Wha

Te Whare Tapa Whā identifies four dimensions of wellbeing for individuals (Durie, 1994). These are Te Taha Hinengaro (mental and emotional wellbeing), Te Taha Wairua (spiritual wellbeing), Te Taha Tinana (physical wellbeing) and Te Taha Whānau (social and family wellbeing).

Durie (1984) identifies Te Taha Hinengaro as thoughts, feelings and behaviours which are vital to well-being, and the capacity to communicate, to think and to feel. Durie and Kingi (1997) indicate that elements of mental health can be seen in the ability of individuals to manage emotions and thoughts, as well as the patterns of thought that can contribute to overall mental wellbeing.

Te Taha Wairua is described by Durie (1984) as the 'capacity for faith and wider communion' (p.45). Wairua can also refer to an individual's relationship with their surroundings and environment, their personal history or whakapapa, and the connections between people that are not physical (Durie, 1984). Durie reflects that "without a spiritual awareness and a mauri (spirit or vitality, sometimes called the life-force) an individual cannot be healthy and is more prone to illness or misfortune" (p. 71).

Te Taha Tinana refers to physical wellbeing, and the capacity for individual physical health and development (Durie, 1984). Durie describes physical wellbeing in relation to the presence or absence of pain, freedom of physical mobility, mind and body links, and being able to act on opportunities for enhanced health (Durie & Kingi, 1984).

Te Taha Whānau refers to the social well-being of an individual (Durie, 1984). Social wellbeing can be indicated in relation to an individual's opportunities for social connection, quality of relationships, and sense of belonging (Durie, 1984).

Relationships between the dimensions

Durie (1984) outlines that within Te Whare Tapa Whā, individual health is viewed as an interaction between the four dimensions of the model, with each component being vital to all other dimensions of health. The importance of each component in relation to the others is reflected in the use of a whare as the metaphor for health in Te Whare Tapa Wha. Each wall of the whare is reliant on each other wall to ensure the whare is stable. Balance between the dimensions is required for the whare to remain stable. Te Whare Tapa Whā dimensions are intrinsically related to each other based on the belief that optimal health is attained when all areas are in balance (Durie, 1984).

The relationship between the Treaty of Waitangi and Te Whare Tapa Wha

This section will discuss the place of The Treaty of Waitangi when considering the development of Te Whare Tapa Wha. It will do this by addressing the place of the Treaty alongside the Te Whare Tapa Whā model, and ways that Durie has subsequently considered the Treaty in his writing.

According to Orange (1987), the Treaty of Waitangi is New Zealand's founding partnership agreement between Maori and the British Crown. It sets out the terms and conditions of settlement in New Zealand by non-Maori, and affirms Maori sovereignty throughout all articles (Orange, 1987). It was signed in 1840, and according to Waa (2000) the Treaty identifies the underlying aspirations of health promotion within its principles. Durie (1999) outlines that Te Whare Tapa Whā aligns with the Treaty of Waitangi by providing a rationale for understanding health and sickness in a way which is unique to and based on Maori culture.

Durie's original introduction of Te Whare Tapa Whā (1984) does not explicitly acknowledge the Treaty of Waitangi. Durie explicitly acknowledges the importance of the Treaty of Waitangi when considering health in his later writings (1997, 1998, & 1999). The importance of considering the principles of the Treaty of Waitangi in the delivery of health services is explained by Durie (1998, p.26): 'according to the Treaty, Maori health has a right to official recognition and protection, and Maori people have a right to appropriate services; funded through our health system'.

Durie (1999) explains that there are three areas of the Treaty that are most important when considering Maori health. These areas of Treaty application are described by Durie as 'partnership and participation in understanding health and sickness. (2) Partnership and participation in the development of health policy. (3) Partnership and participation in the delivery of health services' (p.284).

Te Whare Tapa Whā in relation to the wider social and political context of its time

This section describes the social and political context in New Zealand, within which Te Whare Tapa Whā was introduced. This is important to assist in understanding the relevance and application of the model.

Following the arrival of Europeans in New Zealand, the Maori population decreased

by over 60% because of the introduction of diseases such as influenza and measles between approximately 1800 and 1870 (Durie, 1997; Kukutai, 2011, O'Malley, 1997). This decline in population occurred alongside the illegal confiscation of land from Maori between 1850 and 1870, and the discouragement and repression of the use of Maori language and culture, particularly in schools (Durie, 1994; Ministry of Culture and Heritage, 2017; Pool, 1991).

The repression of Maori access to health services throughout the 1800's has contributed to ongoing health differences between Maori and Pakeha which have persisted since, and which are consistently reflected in inequalities of health outcomes today (Durie, 1997; Kukutai, 2011, O'Malley, 1997). Examples of these differences are reflected in the most recent health status indicators data available from the Ministry of Health (2015).

Health status indicators data reflects that Māori adults were about 1.5 times as likely as non-Māori adults to report a high or very high probability of having an anxiety or depressive disorder. In addition to this, Māori suicide rates were nearly twice as high as those of non-Māori, with the disparity being greater for females. Māori females were more than twice as likely as non-Māori females to complete suicide, and Māori overall were significantly more likely than non-Māori to be hospitalised for intentional self-harm in 2012–14. Māori were almost twice as likely as non-Māori in the same age group to have been hospitalised for asthma, and Māori were more likely than non-Māori in the same age group to report being diagnosed with asthma.

The identified continued disparity between Maori and Pākehā health outcomes provided a rationale for the development of a health model which responded specifically to the health needs of Maori, and prompted the Rapuora study (Murchie, 1984) which in turn, provided a basis for the development of Te Whare Tapa Wha.

Breaches of the terms of the Treaty of Waitangi also need to be considered in discussion of the political context of the development of Te Whare Tapa Wha. This is because breaches of these terms, including the illegal confiscation of land and repression of Maori culture, impacted Maori wellbeing. For example, in any given region of New Zealand, Maori land loss was followed by a marked increase in Maori child mortality rates between 1800 and 1896 (Buck, 1924; Newman, 1881; Pool, 1991).

From the early 1980s, the Waitangi Tribunal began to explore and investigate multiple Treaty breaches, both current and historic. In one example, according to the Ngai Tahu report (1991), the Crown reported that it had 'acted unconscionably and in repeated breach of the Treaty of Waitangi' (p.1066) in relation to land breaches with Maori.

Alongside ongoing Treaty settlement issues in the 1980's, there was growing public acknowledgement of the Treaty of Waitangi as New Zealand's founding document (Hayward, 2012). Hayward reports that, 'government departments began to adopt the idea that the languages, cultures and traditions of both Pākehā and Māori should be officially recognised by the state' (Hayward, 2012, p.03). Mulgan (1989) also identifies that any state services were proposing institutional changes which would allow more suitable access and equitable delivery for Maori. These institutional changes possibly provided a further rationale for the development of health models that reflect the cultural needs of Maori, in this period in New Zealand history.

In this context, alongside the introduction of Te Whare Tapa Wha, there were other health models being designed to address Maori health disparity in New Zealand. As well as Te Whare Tapa Whā (Durie, 1985), the two other prominent models of this era were Nga Pou Mana (Henare, 1988) and Te Wheke (Pere, 1988). Similarities among these models include the acknowledgement of spiritual wellbeing as a component of health (Durie, 1985), and the promotion of social connection as integral to health (Glover, 2013).

Relevance of Te Whare Tapa Wha

For the purposes of this study, Te Whare Tapa Whā provides the framework for considering and measuring the wellbeing of addiction practitioners. The selection of Te Whare Tapa Whā was influenced by the presence of Te Whare Tapa Whā in the education curriculum for addiction practitioners, and due to the extensive use of Te Whare Tapa Whā in New Zealand health and social services (Glover, 2013). Te Whare Tapa Whā forms a part of the curriculum for the qualifications required for professional registration of addictions practitioners in New Zealand. Practitioners are currently required to hold certain qualifications as a minimum requirement for registration (DAPAANZ, 2016). Each of these qualifications requires students to explore Te Whare Tapa Whā in the context of Maori health promotion (Moana House, 2018) or Treaty based practice (NMIT, 2018; Wintec, 2018; Weltec 2017).

Te Whare Tapa Whā is applied as a model of practice in New Zealand health and social services, as identified by the Ministry of Health (2017), Matua Raki (2014), Te Rau Matatini (2009), and the Canterbury District Health Board (2017). Te Whare Tapa Whā is also used as a measure of health in many addiction services (Te Rau Matatini, 2009). It is assumed therefore that many practitioners will already be familiar with the concepts that underpin the model.

The dimensions of Te Whare Tapa Whā are used as the core considerations for many mental and physical health assessments in New Zealand, including Hua Oranga (Durie & Kingi, 2000), the Assessment of Mental Health and Wellbeing for matching to Therapy (Te Pou, 2015), and the Tamariki Wellness Assessment (Ruwhiu, 2009). These assessments are examples of how Te Whare Tapa Whā has directly underpinned the development of health and wellbeing assessments New Zealand. With these applications of Te Whare Tapa Whā considered, there is a rationale to support the validity of Te Whare Tapa Whā as a standardized measure of wellness for practitioners.

Application to the current research

Te Whare Tapa Whā provides the theoretical framework for the current research. This research also uses the dimensions of Te Whare Tapa Whā to underpin the design of all questions, and to provide the explicit categories for data coding and the discussion of findings. Te Whare Tapa Whā provides a way of framing and thinking about the impact of employment in addiction services in terms of a practitioner's wellbeing.

Conclusion

This chapter has introduced and discussed Te Whare Tapa Whā as the theoretical framework to consider the underpinning principles of individual health and wellbeing for Maori and its uses and application in the consideration of individual health and wellbeing for wider New Zealand health and social services. It has discussed the purpose, aim, and wider social political context of Te Whare Tapa Whā in Aotearoa New Zealand, the place of the Treaty of Waitangi, and the significance of Te Whare Tapa Whā for current health education and practice in New Zealand. Chapter three will draw further on this discussion to critically discuss the literature in the fields of

wellbeing for alcohol and other drug practitioners, and how Te Whare Tapa Whā has been considered and applied in other relevant research in New Zealand.

Chapter Three
Literature Review

This chapter will review existing literature in the areas of workplace health and wellbeing, followed by a review of research which applies Te Whare Tapa Whā. Literature will be reviewed which broadly considers the wellbeing of practitioners employed in healthcare related fields. This literature is included to illustrate the scope and perspectives that already exist in research into practitioner wellbeing. Following this, literature which applies Te Whare Tapa Whā as a research tool in the fields of health, social services, education and corrections will be considered.

To identify the most relevant literature to review for this study, a comprehensive search of articles and research in the fields of healthcare, and specifically for addictions practitioners was undertaken. Initially, key search terms were extracted from the research question, including the terms 'addiction practitioner', 'wellbeing', 'health', 'impact' and 'workplace'. Research databases searched included Mendeley, EbscoHost (Proquest, CINAHL, and Summons), Spydus and Google Scholar. Abstracts of potentially relevant research were also reviewed. Publications that were likely to offer content of direct relevance to this dissertation, including the Journal of Substance Use and Misuse, as well as the Journal of Practitioner Research were also reviewed. These journals were included as they include research that is specifically relevant to practitioners employed in the field of addiction.

Search inclusion criteria was initially restricted to literature which had been produced in the last 5 years, however as the research progressed it was clear that there were fundamental documents written outside of the five-year restriction which required consideration. Examples of these documents include the vital consideration of the Treaty of Waitangi (1840), as well as the Te Whare Tapa Whā (1984).

Further restrictions included a 'scholarly and peer review' filter being applied to searches, as well as content type being a journal or article. Dissertations and Theses were later added to content type inclusion. Disciplines searched included social welfare and social work, public health, social sciences and occupational therapy including rehabilitation.

Of interest was the lack of addiction specific research. The addictions field has been

included within a general health context throughout literature, which includes professions such as nursing and palliative care, rather than the specialized field of addiction. Also, worth noting is how little New Zealand specific research is available in an addiction
context. New Zealand health research appears to focus on nursing, general practice and emergency service statistics more frequently when referring to addiction, than it does to harm reduction and addiction prevention efforts.

Because of the lack of addiction specific workforce research, literature to build upon was drawn more generally from wider fields of health care. The themes found within the broader scope of healthcare literature retain relevance, as addiction practitioners do practice under the category of healthcare professionals. Addiction practitioners are required to hold a professional registration in New Zealand (Drug and Alcohol Practitioners Association Aotearoa New Zealand, 2017). Many of the work-related tasks of an addiction practitioner run parallel to the tasks of nursing. These include clinical review, monitoring, and building therapeutic alliance (Koinis, Giannou, Drantaki, Angelaina, Stratou, & Saridi, 2015). In addition, the health outcomes of the client are paramount, as they are in nursing. For these reasons, literature has been drawn heavily from the field of nursing.

The health outcomes of nursing staff and general practitioners employed in hospital and community settings internationally has been explored throughout literature (Kanaskie, 2006; Kleinman, 2004; and Scanlon, 2001). These studies view health outcomes through a variety of lenses and using a variety of methodologies. Less common is research that focuses specifically on how the practical dimensions and tasks of these roles impact on an employee, independent of the workplace. As discussed, related research can be found in nursing (Laschinger, Leiter, Day & Gilin, 2009), long term aged care (Tsukamoto, 2015), and human services in general (Ogino, 2004), however research specific to the wellbeing and health outcomes of addiction treatment staff is not available.

The theme of decreased stress tolerance as a direct result of employment in healthcare related fields, was raised repeatedly as an issue in the literature. Stress tolerance can be defined as maintaining effective performance under pressure or adversity (Burns, 2006). The impact of decreased stress tolerance on an employee's general life is deemed to be significant (Koinis et al., 2015; Bakker, 2000; Fagin, 1995).

According to Fagin (1995), decreased stress tolerance will have an impact on employee social life, families, values and spirituality. The core aim of Fagin's work was to evaluate the levels of psychological distress on nurses in Northeast Thames in the United Kingdom.

The Claybury CPN Stress Study was provided to mental health nurses in 15 of the 16 health districts in Northeast Thames. Fagin collected data from 568 community and residential health care employees (equating to 80% of the total mental health nurse workforce in Northeast Thames), and found that these staff experienced the impact of the stress in their work lives in a variety of ways. Occupational burnout and emotional exhaustion were identified as common themes among these staff, with Fagin concluding that 'serious consideration of introducing stress-reducing measures in the workplace as well as further research into specific stressors is required' (p.347).

Fagin (1995) identified that life satisfaction, self-esteem, and physical wellbeing were all affected by employment as a mental health nurse. Staff with better physical fitness were also noted to gain more meaning and enjoyment from their work. The work of Fagin is unique in terms of the identification of multiple facets of life contributing to occupational stress and burnout.

The relevance of the work of Fagin when considering the wellbeing of practitioners employed in addiction services can be seen in the aim of this work. Fagin aimed to evaluate the levels of psychological distress on nurses as a result of their roles. There is a relationship between this research and research which aims to measure practitioner wellbeing in a broader sense.

Also apparent in the literature is the theme of resilience in healthcare employees, and the impact of increased resilience on other areas of their non-work lives (Unrath, 2012). Unrath aimed to identify 'health risk factors' among healthcare professionals working in outpatient settings in Germany. The motivation for this study was to address what Unrath described as 'inconsistent findings with respect to substance use disorders among clinicians' (p.2). Of interest to this author were the risk factors which can contribute to the negative outworking of work related stress in a practitioner's personal life. To identify the personal health risk factors, Unrath developed a survey that was issued to general practitioners in Germany, which gained 808 responses. 2,092 practice-based general practitioners were invited to participate in the survey, which was sent via postal mail.

The findings showed that employment in health-related fields provides continued exposure to what could be considered traumatic content. The findings suggest that this continued exposure increases tolerance to traumatic content and may skew what healthcare employees deem to be troubling, or a ‘crisis’. The theme of increased detachment was also identified in relation to developing a tolerance for ongoing stress. Despite increased tolerance to stress in the workplace, Unrath discovered that many healthcare professionals were using alcohol to manage their stress levels at home. ‘The prevalence of Alcohol Use Disorder in the sample was 18.9%’ (p.3). The study also uncovered that 25% of the sample reported consumption of alcohol daily.

Unrath emphasized the need for health professionals to maintain empathy for those around them who are not constantly exposed to stimulus of this nature, to ensure they, the healthcare professionals, are not perceived as ‘cold’ and detached from human empathy. Within the work of Unrath (2012), the theme of increased resilience for healthcare professionals was noted. Unrath described resilience as a ‘sort of hardiness’ that develops in the face of strain. Unrath found that practitioners with higher resilience ratings had a lower chance of suffering from substance use disorders, than those with lower resilience ratings. He argued that resilience could be developed with increased exposure to challenging stimulus.

There is direct relevance between the work of Unrath, and research that is specific to addiction practitioners. This is in relation to the similarities between outpatient addiction specific work, and outpatient general healthcare work. Both roles are client facing, with relatively short engagement time between one client and the next. Although Unrath does not mention the impact of a practitioner's spirituality, this consideration cannot be ignored when designing health research in a New Zealand setting.

According to Koinis et al. (2015), healthcare practitioners tend to experience higher rates of workplace stress and burnout than employees in other fields. A contributing element to a higher rate of workplace stress is in relation to a perceived effort-reward imbalance, where practitioners are not yet prepared for the reality of working with chronic, relapsing conditions. Koinis et al. (2015) investigated how employment in healthcare related fields can impact on employees’ physical and emotional wellbeing, and at times, have a negative impact on their overall quality of life.

The aim of this study was to explore the impact that employment in client-facing healthcare roles can have on the employees' 'mental emotional health' (p.3), and to develop interventions to prevent the progression of any negative impact.

The study was conducted through a standardized questionnaire that was completed by 200 healthcare professionals (nursing and medical staff) aged 21-58 years working in a 240-bed general hospital in Greece. The core conclusion of this study was that 'in general, health care professionals are more prone to stress and professional burn-out, because they are responsible for human lives, and their actions, or lack of action, can have a serious impact on their patients' (p.4).

A limitation of this study is the narrow geographical scope (studying one hospital in Greece) and therefore, results from this study cannot be considered representative to other regions. In addition, Koinis et al. (2015) also noted that there could not be certainty that participants responded to the questionnaire with complete honesty. Although this is a valid limitation, complete honesty should be considered a limitation in any data gathering that is based on self-perception and reflection (Hoskin, 2012).

Another limitation for the purposes of the proposed research is the relevance of findings in the New Zealand context. It is suggested that explanation would be required to understand the differences and nuances of the cultural influences and perceptions of stress and burnout in different regions.

There is direct relevance between addiction specific research and the work of Koinis et al. (2015). This relevance can be found in the broad scope that Koinis et al. (2015) applied to measure wellbeing. Dimensions of wellbeing that Koinis et al. (2015) explored throughout this study included physical, mental and social wellbeing.

Of further relevance to addiction specific research is in relation to the study conclusions. Koinis et al. (2015) concluded that there are many interventions that could improve, as well as stabilize, the physical, mental and social well-being of healthcare practitioners.

A theme in the literature is the recommendation for out of work activities that are calming and relaxing to help manage the impact of employment in parallel healthcare fields, such as nursing and aged care. This theme is evident in the work of other researchers in the field. Mészáros (2013) investigated the methods employed by

healthcare professionals in relation to personal coping mechanisms. According to Meszaros (2013) there are high rates of depression and burnout among health care professionals in Hungary. Meszaros aimed to evaluate the role of coping mechanisms in preventing depression and burnout among this group.

To explore this, Meszaros investigated the methods employed by healthcare professionals in relation to personal coping mechanisms. The research involved a survey of 1333 health care professionals in Hungary, who completed questionnaires outlining their preferred coping strategies, and the effectiveness of these strategies from their own perspectives. It was found that staff who prioritized time alone to reflect were found to be able to 'reduce the probability of the development of burnout and depression symptoms' (Mészáros, 2013; p.1). In addition to this, Meszaros noted that staff who could make a realistic assessment of challenging situations were less likely to develop burnout and depression symptoms.

Although this study is limited to the measurement of stress and burnout in healthcare employees, it does highlight potential interventions that could be effective in terms of intervention of stress and burnout. This study provides an opportunity to further develop an intervention package for healthcare employees in a New Zealand, and in addiction specific contexts. A limitation is that although potential solutions are identified, causal factors are not described or noted fully. The step of identifying causal factors of depression and burnout in a population would seem important when attempting to identify prevention measures.

Similarly, the research of Hillert (2012) indicates that healthcare employees who prioritise relaxation and symptom reduction activities (low stimulus activities) experience less workload related suffering. The aim of Hillert's work was to investigate and develop treatment approaches that were effective for job related stress in health care settings.

The data set included 88 adults in a German hospital. Hillert (2012) invited healthcare professionals employed within the hospital with self-perceived 'above average' level of stress and separated participants into a control group and an intervention group. The intervention group were invited to participate in relaxation techniques with low stimulation, and out of work self-care. These included stress management interventions such as time alone participating in exercise, and mindfulness techniques. Hillert noted

that the primary outcome was a ‘change in perceived stress at six months post-intervention for the intervention group. This change was measured using a standardized questionnaire.

Although the work of Hillert (2012) and Mészáros (2013) may not be directly applicable in a New Zealand context, the themes for healthcare extracted from their research can serve as a guiding consideration when designing research for a New Zealand setting. Hillert also concluded that the term ‘burnout’ may be confusing, as the term has no scientific measure, and is based purely on an individual's perception and reaction to their environment. Hillert notes that any burnout intervention would therefore need to be based on what could be effective for an individual, rather than an intervention for an entire group. There is relevance between Hillert’s research and addiction specific research, as the conclusions that Hillert noted in terms of broad terminology (such as ‘burnout’) and individualized intervention need to be considered for relevance in a New Zealand specific health context.

The literature shows that many health professionals identify a need for increased time alone outside of work (Elbarazi, 2017; Stöckigt, 2015; Yasmin, 2011). The need for increased time alone has an impact on the family and social relationships of those people employed as healthcare professionals, according to these authors.

The work-life balance of those employed in health care services was explored in depth in a longitudinal study by Shanafelt (2015). Shanafelt invited 35,922 physicians and health workers in the United States (US) to complete a series of online surveys which aimed to evaluate the prevalence of burnout and satisfaction with work-life balance in physicians and US health workers, and 6880 (19.2%) completed surveys. The surveys used standardized assessments to gauge the work life balance of physicians and health workers.

According to Shanafelt, ‘burnout and satisfaction with work-life balance in US physicians worsened from 2011 to 2014. More than half of US physicians are now experiencing professional burnout’ (p.1593). In response to this phenomenon, Shanafelt provides recommendations for supporting the work life balance of practitioners and notes the opportunity for further longitudinal study to gauge the effectiveness of interventions designed to improve the work life balance of physicians and other healthcare workers in the United States.

The explicit relationship between the health outcome and the professional practice of the individual provides relevance when considering research design specifically for addiction practitioners. Additionally, the importance of gauging the effectiveness of any intervention is promoted by Shanafelt (2015). This consideration forms an opportunity for further research relating to the effectiveness of support measures designed to support addiction practitioners specifically.

The social wellbeing of healthcare professionals was also explored by Makhado (2016). Specifically, this study aimed to identify if there was a relationship between the social and mental wellbeing of nurses, and their roles in caring for people living with HIV/AIDS. The study consisted of a self-administered questionnaire, which was hand-delivered to willing participants. The study attracted 233 responses. This study included only nurses who were caring for this group specifically, employed in the South African province of Limpopo.

Findings showed significant themes of stigma and discrimination, emotional exhaustion, and depression among nurses caring for people with HIV/AIDS. According to Makhado (2016), 'stigma and discrimination were found to be the main predictors of emotional exhaustion and depersonalisation, while positive peer relations predicted personal accomplishment among nurses caring for people living with HIV/AIDS' (p.15).

There is direct relevance between to work of Makhado (2016), and addiction specific research. The relevance can be found in the recommendation of prioritizing social supports for people caring for populations who are vulnerable to stigma (such as people living with HIV/AIDS and addiction). Makhado (2016) stated that 'social support has been one of the largest predictors of reductions in burnout and stress for nurses; hence it should be taken into consideration in dealing with the psychosocial wellbeing of nurses' (p.08).

To develop social supports for healthcare practitioners, Makhado (2016) suggested that employers could contribute to their employee's social wellbeing by organizing spaces and forums that allow nurses to connect with each other, and 'voice their concerns and anxieties' (p.08).

Throughout literature, the physical impact of employment in a health-related field was discussed. Employment in healthcare related fields has been noted to be a highly stressful endeavour (AbuAlRub, 2004; Bianchi, 2004; Engel, 2004; Callaghan, Shui &

Wyatt, 2000; Shirey, 2006; Stacciarini & Troccoli, 2004; Tseng, 2004; Xianyu & Lambert, 2006).

Yao (2008) investigates the impact of employment on a practitioner's physical health, employed in health-related fields. Yao investigated the relationships between work-related stress, health status, and physical activity of nurses practicing in hospitals in Taipei, Taiwan. The specialization of these nurses was not discussed. Participants were selected from five hospitals. The research administered a survey. The survey was completed by four hundred and twenty nurses. The survey consisted of four standardized measurement tools for physical wellbeing, including the Nurse Stress Scale (NSS), the SF- 36 Health Survey, the Stage of Exercise Scale (SOES), and the Seven-Day Physical Activity Recall Questionnaire (2004).

The study found that nurses with higher levels of physical activity reported lower levels of stress. The results also showed that, 'participants who had not participated in exercise experienced lower physical and mental health than those who had participated in exercise and physical activity in the same period' (Yao, 2008; p.06).

Recommendations for improving nurses physical and mental health were explored, with Yao (2008) stating that 'nurses need to be aware of the benefits of physical activity in buffering stress by active participation in physical activities. By actively participating in exercise and leisure activities, nurses will be able to, at least, maintain their health status, their job performance, and boost their self-confidence' (p.148).

A limitation within the research of Yao (2008) is that the relationship between the physical wellbeing of the nurses was not specifically linked to their work as a nurse. Although standardized measures were used to measure physical wellbeing, these measures do not give an opportunity for respondents to state the impact of their role in response to these measures. The impacts of family commitment, life stress and financial situation for example were not distinguishable from professional practice.

Despite a lack of New Zealand specific and current research, the work explored in the international literature provides a set of themes and considerations that will be useful in designing New Zealand addiction specific research in this area. These considerations include the need for research design which asks healthcare workers to specifically reflect on the impact of their roles on their individual wellbeing. Themes emerging from literature, including the levels of stress and burnout among healthcare practitioners,

encourage further exploration of the reasons for these symptoms occurring among healthcare workers.

Te Whare Tapa Whā in literature.

The scope of Te Whare Tapa Whā within research is broad. The Whare Tapa Whā has been applied in various health, education and social studies. An overview of Te Whare Tapa Whā's application in health and social research, and in education is explored here.

Application in Health

The application of Te Whare Tapa Whā was most prevalent throughout literature when applied in health contexts. This is unsurprising, considering that the model was designed to address health issues in a New Zealand context.

The application of the Te Whare Tapa Whā model as a framework for wellbeing is evident in the research of Waitoa (2014). The key question that Waitoa set out to address was 'if a Māori model of health would work better to improve Māori health status' (Waitoa, 2014; p.69). Waitoa utilized a case study approach, interviewing 10 staff who were employed in Kaupapa Maori health services. These staff were actively involved in delivering health services to Maori. The purpose was to observe the outcomes achieved by Kaupapa Maori health services when they applied Maori health principles to health service delivery.

Waitoa (2014) introduces the concept of a Maori response to health disparities in New Zealand, specifically in relation to the disproportionate burden of health problems that Maori are experiencing compared to the rest of the population, identified by Waitoa. Waitoa (2014) argues in discussion that 'Māori health disparities are best addressed via the development and delivery of Māori health models by services which are oriented to Kaupapa Māori principles' (p.2). The discussion supported the effectiveness of utilizing Te Whare Tapa Whā when assessing wellbeing in a New Zealand context.

Despite the small sample size and the lack of comparison to other New Zealand health models, Waitoa provides a depth of discussion about the application of Te Whare Tapa Whā that provides a rationale for the inclusion of the model in an addiction context. Although the application of Te Whare Tapa Whā is evident throughout the research

design and interview, there is a concern that the outcome of this research may have been different if the sample size was bigger. In addition to this, perspective that is gained from front line staff (such as those interviewed by Waitoa) may be different than the perspectives of senior policy writers, or Ministry of Health executives, it would have been useful to read a broader cross section of responses around a Maori model of health. Investigation into the differing perspectives between frontline workers and policy makers would be useful to explore in further research.

Glover (2005) also advocated for the use of Te Whare Tapa Whā when analysing Maori smoking cessation behaviour. Glover interviewed 130 female smokers who self - identified as Maori and were living in New Zealand. Glover interviewed these participants pre- and post-engagement with a smoking cessation program. The dimensions of Te Whare Tapa Whā were applied throughout question design and the organization of findings. According to Glover (2005), 'Te Whare Tapa Whā was used as the primary organising framework for grouping the findings into sections' (p. 02).

Thematic analysis of the interviews found that patient motives for smoking could be attributed to the elements of Te Whare Tapa Wha. An example of this was in relation to the finding that 48% of participants identified that they used nicotine to manage stress. This use of nicotine, according to Glover, fits within the mental health area of Te Whare Tapa Wha. This is because the management of stress is attributed to the mental health of an individual according to Glover.

Glover applied Te Whare Tapa Whā as a framework for grouping the findings. For example, 'attitudes towards and beliefs about smoking while pregnant and motivation to stop smoking were included under Te Taha Hinengaro (mental wellbeing). The home and social environment and smoking and attitudes of others fitted into the Te Taha Whānau dimension (p.15).

Glover (2005) concluded that when smoking cessation programs were delivered in a manner that considered the patient 'holistically', smoking cessation was achieved for periods of time that were longer than those interventions which only addressed the smoking behaviours. Glover found that an effective intervention when reducing Maori smoking prevalence includes dimensions that address smoking damage to the physical, mental and spiritual health of the person and their Whanau' (p.127).

Although it is unclear if the findings of Glover's work would be similar with a cohort that did not self-identify as Maori, the research offers an approach of applying Te Whare Tapa Whā when measuring wellbeing.

Application of Te Whare Tapa Whā is also evident in the work of Wyeth (2015). The aim of this study was to identify pre-injury and injury-related predictors of life satisfaction three months after injury. Wyeth interviewed 566 New Zealanders, aged 18–64 years, who were on an injury entitlement claims register with New Zealand's compensation insurer (ACC). The findings showed that 71% of participants reported satisfaction with life three months after injury, compared to 93% pre-injury.

According to Wyeth (2015), 'the well-known Te Whare Tapa Whā model of overall health and well-being was used to help inform the selection of post-injury life satisfaction predictor variables' (p.01). Life satisfaction was measured through the lens of the Te Whare Tapa, with participants invited to share the impact of their injury on their social, physical, spiritual and mental health. These factors of health were presented by Wyeth as indicators of life satisfaction.

A link was made between the findings of this research and Te Whare Tapa Wha. Wyeth (2015) noted that participants who had higher levels of satisfaction with their spiritual, mental, physical and social lives had higher levels of life satisfaction overall three months post injury. Wyeth specifically linked dimensions of Te Whare Tapa Whā with potential variables in each area. For example, under the whanau dimension, Wyeth identified global social relationships and family involvement as potential variables. Participants were then able to share if they were satisfied or not satisfied with each variable.

The research of Wyeth has relevance to research which seeks to explore the wellbeing of health care practitioners using Te Whare Tapa Whā as a basis for thematic analysis. According to Wyeth (2015), Te Whare Tapa Wha, 'has been used as a framework to help inform' (p.12) the design of the research. The use of Te Whare Tapa Whā by Wyeth as the conceptual parameters for data gathering could be considered when designing addiction specific research.

Te Whare Tapa Whā has also been applied as a framework for presenting results in a feasibility study led by Dyall (2011). The purpose of this work was to investigate the feasibility of whether Maori of advanced age would be interested in, and able to take

part in a quantitative study involving a comprehensive questionnaire, physical health assessment and blood analyses (a range of biological markers). Dyall (2011) engaged the participation of 33 Maori, aged 75-70 years, who were living in the Bay of Plenty and Lakes DHB areas to scope interest for further longitudinal study.

Participants were identified through Maori health providers, who knew the potential participants. These participants were invited to respond to a wide range of quantitative health related questions, as well as participate in interviews and physical assessments. 45 participants who self-identified as Maori were invited by their health providers to participate in the study. Twelve of those potential participants declined to participate, and thirty-three agreed.

Dyall (2011) applied Te Whare Tapa Whā within the research design and methodology of this study. This application is reflected in the development of questions and indicators that relate to the dimensions of Te Whare Tapa Wha. Questions relating to spirituality were asked directly to participants, including 'the importance of spirituality in daily life' (p.05). Biological factors of physical wellbeing were measured using physical checks from participants general practitioners with participants also being invited to share other physical health concerns with their interviewers. The participants were given the option to respond to the study in te Reo Maori if this was preferred.

According to Dyall (2011), 'Maori questions developed in the feasibility study are unique and they link with previous research with Maori of advanced age. The questionnaire developed for this study used the Te Whare Tapa Whā model of health, and included recognition of participation in whanau, involvement in the community, iwi (tribal) and hapu (extended family) activities, use and importance of Te Reo' (p.04).

The application of Te Whare Tapa Whā throughout the study was also evidenced by explicit reference to participant participation in whanau, and involvement in land and Marae matters (Dyall, 2011). Te Whare Tapa Whā is also reflected in the findings of the feasibility study, with sections titled tribal and whanau links, cultural values and religion, whanau engagement and recreational activities, and physical health status. Also reflective of Te Whare Tapa Wha, was the inclusion of questions which explored participants' understandings of their whakapapa, their participation in spiritual and religious pursuits, their levels of family support, and how physical wellbeing is monitored. The inclusion of these questions when exploring the individual wellbeing of a sample reflects the multidimensional view of health which is presented by Te Whare

Tapa Whā. The feasibility study findings included that most participants would like to participate in a longitudinal cohort study. The discussion section of the study stated that, 'the overall response from Maori participants and their supporters has been positive. Following the dissemination of the results they have affirmed that such a cohort study should be undertaken for the benefit of others, especially for those who follow behind in their shoes' (Dyall, 2011; p.12).

Within this study, there is relevance to the topic of the impact of addiction specific work on addiction practitioners. This study has been included in the literature review to illustrate the application of Te Whare Tapa Whā as a framework for assessing wellbeing. There are considerations for research design in an addiction context that can be identified throughout the design and methodology of the work of Dyall (2011). Dyall's (2011) work provided a working definition of Te Whare Tapa Whā as 'an overall framework and context to develop the questionnaire and present the results' (p.01). This approach could be considered for research in an addiction specific context.

Te Whare Tapa Whā has also been identified as an effective measure for considering the occupational stress and wellbeing of Maori employed in healthcare services (Gardner & Stewart, 2015). The aim of this study was to add to what the researchers identified as limited research about occupational stress among Maori. The researchers interviewed 108 Maori health and disability sector employees, exploring the coping strategies that these participants used when dealing with work related stress.

This research was developed to respond to what the researchers identified as a gap in information that specifically considered occupational stress levels among Maori. According to the researchers, 'very little Aotearoa New Zealand research has been published on occupational stress among Maori' (Gardner & Stewart, 2015; p.01).

The dimensions of Te Whare Tapa Whā were used as the basis for data analysis when considering the stress levels of occupational stress among Maori employed in healthcare services. Participant interview responses were divided into four 'strains', with each strain representing a domain of Te Whare Tapa Wha. 'Participants were asked to rate through a survey how true each item was on a scale from 1 (rarely or never true) to 5 (true most of the time), with a 'not applicable' option.' (Gardner & Stewart, 2015; p.32). For example, the response 'I feel good about myself because of the mahi I do' was coded as an indicator of the Te Whare Tapa Whā pillar 'wairua' (p.32).

The findings of Gardner & Stewart's 2015 study included that the key contributing factors for occupational stress of Maori employed in healthcare services included, 'experiencing institutional racism, lack of recognition, workplace support, and lack of appropriate cultural or professional supervision. Stress, burnout and high rates of turnover among Maori staff were key negative outcomes of high work demands' (p.02).

The purpose for including this research within this literature review is to illustrate the application of Te Whare Tapa Whā when measuring the health and wellbeing of healthcare practitioners, which is relevant as Te Whare Tapa Whā will also be applied to measure the wellbeing of addiction practitioners in this study. Gardner and Stewart (2015) illustrate how the model can be used to inform the parameters of research questions or statements, and how the dimensions of Te Whare Tapa Whā can be applied when coding data.

Stevenson (2001) applied Te Whare Tapa Whā when investigating the relationship between Maori cultural identity and health. Stevenson hypothesized that a stronger cultural identity would be positively correlated with better health outcomes for Maori. For the purposes of this study, cultural identity is defined as 'the degree to which an individual identifies with their particular culture' (p.iii). The data set for Stevenson's study was already available in the form of survey responses from Te Hoe Nuku Roa, a longitudinal study published in 1999 with a baseline survey of 1574 individuals, covering 655 Māori households (Te Hoe Nuku Roa, 1999). The Hoe Nuku Roa research was completed by the Whaihua Tatau team (Fitzgerald, Durie, Black, Durie, Christensen, & Taiapa, 1996). The Hoe Nuku Roa sample included five New Zealand regional council areas. Participants were selected using a differential sampling approach based on ethnicity information from the 1996 New Zealand census (Statistics New Zealand, 1996).

This research referenced Te Whare Tapa Whā for its provision of an operational definition of health throughout the study, and stated the dimensions of Te Whare Tapa Whā when measuring cultural identity. This application is evidenced by the questions which explicitly relate to the dimensions of Te Whare Tapa Wha. For example, questions asked participants if they exercised or participated in a fitness program in the past month. This was aligned to the dimension relating to physical wellbeing from Te Whare Tapa Wha, Taha Tinana. Stevenson (2001) defined taha whanau (social wellbeing) by referencing Durie (1994) in a statement outlining that 'the health of Māori

is bound with the strength of their relationships to their whanaū' (p.49).

Stevenson (2001) found that participants with a higher level of cultural identity experienced better health outcomes than those with low cultural identity. Lower rates of smoking, and increased involvement in sporting activity were reflected for participants with high levels of cultural identity (p.iv).

Stevenson's work illustrates the usefulness of Te Whare Tapa Whā when defining and measuring individual health. Stevenson (2001) also discussed that many non-Maori models of health do not consider cultural and spiritual values that may be associated with health for Maori. Use of Te Whare Tapa Whā in Stevenson's work aims to address spirituality through the administration of questions which aim to measure spiritual values and beliefs, and the application of this within the study.

Application in Education

Te Whare Tapa Whā is recognized as providing the definition of wellbeing within the New Zealand Health and Physical Education Curriculum (Ministry of Education, 2014). When describing health and physical education within the New Zealand Physical Education Curriculum, the term 'Hauora' (health, wellbeing) is used when referring to wellbeing for students from year 1 to year 13 of their education. An explanation of this term is provided in the explanatory documents of the health and education curriculum as follows: 'in health and physical education, the use of the word hauora is based on Mason Durie's Te Whare Tapa Whā model (Durie, 1994)' (TKI, 2014).

The application of Te Whare Tapa Whā within secondary mathematics education in New Zealand is seen in research by Averill (2012). Averill aimed to explore the factors that contribute to strong teacher-student relationships in multi-ethnic mathematics classrooms. To explore these factors, the researcher drew from 100 Year 10 mathematics lesson observations, involving six teachers and their classes across three urban schools in New Zealand.

Qualitative data were collected over a two-year period, with a standardized observation schedule which was designed to 'record the behaviours of teacher and students which would indicate establishing or maintaining caring teacher student relationships and student engagement' (Averill, 2012; p.124). The observation schedule included items such as eye contact, smiles, use of humour, listening, greetings, and use of Maori in

the classroom. Each observation item was then attributed to the most directly relevant dimension of Te Whare Tapa Wha. Averill used the domains of Te Whare Tapa Whā to develop measurement indicators of a learning environment which reflects each dimension. Examples of indicators created in response to mental wellbeing (Taha Hinengaro) included 'teacher creates a safe and purposeful learning environment' and 'teacher creates a fun and engaging learning environment' (Averill, 2012; p.105).

To further refine each indicator in relation to the Te Whare Tapa Whā dimension, Averill (2012) suggested specific teacher behaviours which could be tallied during observation. One example of a teacher behaviour related to Taha Hinengaro was, 'teacher interacts personably and respectfully' (Averill, 2012; p.105). These observations revealed that the factors that contribute most significantly to strong teacher-student relationships, could be grouped directly within the relevant dimensions of Te Whare Tapa Wha. In this way, Te Whare Tapa Whā has been applied as both a data gathering parameter, and a framework from which to contextualize the research data.

Findings from Averill (2012) showed that in classrooms where all elements of the Te Whare Tapa were apparent, according to the dimensions of the observations schedule, there was higher student engagement.

A limitation of the study of Averill (2012) is the scope for subjectivity in the descriptions provided for the indicators of Te Whare Tapa Wha. The researcher reflects on this issue by stating that 'the researcher in this article is New Zealand European; therefore, given the multi-ethnic focus of the investigation, particular and careful attention was given to culturally responsive research methods and models for analysis' (Averill, 2012; p.111). To ensure that the research was culturally responsive, the Averill (2012) gained the participation of two cultural advisors, who were consulted throughout the study.

The engagement of cultural advisors is relevant to the application to Te Whare Tapa Whā when considering the impact of employment in addiction services on addiction practitioners. This is because the cultural dynamics that underpin the development of Te Whare Tapa Whā need to be understood by the person applying the model to research. Although the indicators for the current research were specifically sourced from the work of Durie & Kingi (2000, p.34), careful consideration needs to be given to how these indicators are linked to the responses provided, and further applied to each dimension of Te Whare Tapa Wha.

Te Whare Tapa Whā has also been used as a tool to measure learner engagement in education settings. In 2012, The Trade and Commerce Commission worked with education providers to gain understanding about how strengths-based frameworks could enhance learner engagement (Hay & Campbell, 2012). Learners included in this study were 16 years or older and enrolled in programmes 'between Level One and Three on the National Qualifications Framework' (p.05).

The researchers discussed that 'learner engagement is crucial to success in educational programmes. However, engaging students in learning is a constant challenge for tertiary providers' (p.7). To respond to this challenge, Te Whare Tapa Whā was used as the basis for the development of a learner engagement framework called 'My Voice', which is described as 'a strengths-based engagement framework designed to help learners focus on their abilities; to help them discover their strengths and to use them on the course as well as in future training and employment (p.12).

Te Whare Tapa Whā was selected as the basis for this framework due to the resonance of the dimensions with what the researchers hypothesized were key considerations when increasing learner engagement. The core dimensions of the My Voice engagement framework were built upon the four dimensions of Te Whare Tapa Wha.

Te Whare Tapa Whā is applied in the design of the 'My Voice' engagement framework, which asks students to reflect on the supports they have available to engage in their learning. In relation to taha tinana, students are asked to share if they 'have the physical resources to do this course' (p.15). Physical resources were defined as students having enough food and energy to get through the learning. Other dimensions of Te Whare Tapa Whā are applied in the same way, with students reflecting on their mental ability to cope with their learning, as well as their self-belief in their ability to learn. In response to student feedback to these questions, individual plans were developed for each student to support their engagement in learning.

The My Voice approach to engagement was then integrated throughout the students' usual program of learning. The study included two groups of students: one group learning with the My Voice approach (31 learners in total), and a control group (28 learners in total). A comprehensive training program was provided for all educators who would be working with the My Voice participants, prior to their work with these

students. Surveys and focus groups were used to measure the engagement of learners prior to and following their learning experience.

Survey and focus group data showed that student engagement was higher in the trial group, than it was in the control group. Focus group data indicated that trial group 'learners indicate a higher level of hope for course completion and achieving future aspirations' (p.22). According to the study, the contribution of Te Whare Tapa Whā to improved engagement was noticeable. This was attributed to the dimensions of the framework being explicitly prioritised and illustrating the importance of 'strengthened learner relationships with tutors' (p.27).

Like Averill (2012), a possible limitation of the My Voice (2012) research is that there is scope for subjectivity in the descriptions provided for the indicators of Te Whare Tapa Wha. Cultural advice and guidance when considering the application of Te Whare Tapa Whā was not indicated throughout the My Voice (2012) study. The importance of cultural advice and guidance when applying a Taonga to academic research is an important consideration, and of relevance to addiction specific research in terms of ensuring culturally appropriate application.

Application in social services

Te Whare Tapa Whā has also been identified as a tool to assist in exploring the experiences of 26 Maori social workers employed within social service organizations in New Zealand (Hollis-English, 2012). Hollis-English (2012) utilized Te Whare Tapa Whā to assist in developing a narrative study investigating the experiences of Māori social workers within government, non-government, Māori, and iwi (tribal) social service organisations through interviews. (p.01). Hollis-English (2012) states that Te Whare Tapa Whā is 'a theoretical framework, a clinical assessment tool, and a method of measuring Maori outcomes' (p.53).

This narrative study aimed to identify the characteristics of positive working environments for Maori social workers and outlined recommendations for services employing Maori social workers to better support them.

Te Whare Tapa Whā was used as a framework for developing a coding system to group the interview findings into themes, which were based upon the dimensions of the model. Examples of identified codes include whanau, tikanga, connections and

fate/sense of calling. Findings highlighted the range of motivations for Maori to become social workers. Many Maori social workers expressed the importance Taha whanau and upbringing on their decisions to become social workers. Whanau influence was therefore applied to the relevant pillar of Te Whare Tapa Wha, Te Taha Whanau (social).

As reflected in this research, there is scope for subjectivity for the application of a dimension of Te Whare Tapa Whā to a participant response (Averill, 2012; Hay & Campbell, 2012). This subjectivity could have been addressed by developing criteria for relating participant responses to a certain dimension of Te Whare Tapa Whā.

The acknowledgement of Te Whare Tapa Whā as a theoretical framework, as well as a method for measuring outcomes has relevance when considering addiction specific research that applies Te Whare Tapa Whā in a similar manner, which is intended in the current study. Hollis-English provides an example of how the model can be applied methodologically as well as practically as a data gathering method.

Stevens (2014) identified Te Whare Tapa Whā as a core component in the development of an Indigenous Framework to support Māori males who have been sexually abused in New Zealand. Stevens (2014) aimed to respond to 'the complexities of Māori social, health and community issues, including sexual abuse' (p.01) by designing a support framework specifically for abuse survivors who identified as Maori.

To explore the design of an Indigenous Framework to support Māori males who have been sexually abused in New Zealand, Stevens (2014) reviewed models of indigenous wellbeing including Te Whare Tapa Whā (Durie, 1994), Te Wheke (Pere, 1988), and Nga Pou Mana (Durie, 1994). Drawing on elements of each of these models, the researcher developed a support framework specifically for use when working alongside sexual abuse survivors.

The inclusion of Te Whare Tapa Whā within the considerations of this support framework are seen in the five core dimensions of the framework, which are titled spiritual wellbeing, emotional wellbeing, community wellbeing, physical wellbeing and intellectual wellbeing. The author explicitly states that the framework of support is based on Te Whare Tapa Whā (Stevens, 2014; p. 26).

Each component includes suggestions for both abuse survivors and support agencies to address wellbeing in that component. For example, environmental wellbeing considerations for survivors include 'reflecting on what resources may be needed now to assist in having or creating a stable environment for recovery' (Stevens, 2014; p.29). Environmental wellbeing considerations for support agencies include 'ascertaining whether the client's environment i.e. home, workplace is safe from further and ongoing abuse / harm' (Stevens, 2014; p.29).

Following the development of this conceptual framework, Stevens (2014) interviewed three academics and specialists with a background in working alongside sexual abuse survivors. The findings from these interviews reflected that 'framework has the ability to be used to assist in the recovery of sexual abuse and that it has good possibilities of securing and protecting cultural identity in the process' (Stevens, 2014; p.42).

Stevens (2014) research is unique from other literature reviewed here in terms of the application of Te Whare Tapa Whā dimensions in recovery planning. This application is useful when considering the design of interventions for those impacted by the nature of their employment, such as addiction practitioners. The usefulness can be reflected in allowing the dimensions of Te Whare Tapa Whā to guide the design of multidimensional interventions to support the workforce in their professional practice.

Pitama (2007) developed a clinical assessment tool named 'Meihana' in an effort to 'operationalise Te Whare Tapa Whā within the mental health system' (Pitama, 2007; p.01). Pitama (2007) recognized that Te Whare Tapa Whā formed the conceptual underpinnings of several practice frameworks within mental health (p.02), however these conceptual underpinnings did not result in an applicable assessment framework that could be used directly alongside those accessing support for their mental health.

To inform the development of the Meihana model, Pitama (2007) interviewed 25 Maori and non-Maori 'health clinicians' (p.119). The sample consisted of psychologists, general practitioners, nurses, social workers and special education advisors. These clinicians were asked to 'describe how they were implementing Te Whare Tapa Whā within their own practice' (Pitama, 2007; p.119). Findings from these interviews indicated that although clinicians were often familiar with the dimensions of Te Whare Tapa Wha, they struggled to put the dimensions of the model into practice when working with clients.

In response to these interviews, Pitama (2007) developed service delivery recommendations that could be applied at a practice level alongside clients (p.121). These service delivery recommendations considered feedback provided from multiple sources, including general practitioners, postgraduate health science students, and undergraduate medical students. Tangata Whaiora and their whanau were also invited to provide feedback.

The explicit relationship between Te Whare Tapa Whā and the Meihana model is evidenced in each service delivery recommendation developed by Pitama (2007). Each dimension of Te Whare Tapa Whā is supported by a working definition, a rationale for inclusion in the model, and a demonstration of the relationship between each dimension and how these dimensions could contribute to improved service provision. For example, the definition of Whanau in the Meihana model is 'client support networks' (Pitama, 2007; p.121). Pitama provides a rationale for the inclusion of whanau in the model by explaining the key role of whanau in assessment, intervention and monitoring the progress of clients. Pitama describes the whanau relationship to services by expressing that whanau should have the opportunity to give feedback to services about their perceived level of cultural safety and competency.

The development of the Meihana model is of relevance when designing research which explores the impact of employment in addictions services on an addiction practitioner. Pitama (2007) illustrates how the Te Whare Tapa Whā model can provide the theoretical framework to underpin recommendations which have the potential to improve service level delivery. This is relevant in an addiction context, as opportunities for the improved support of addiction practitioners can be explored by applying a service level lens to the dimensions of Te Whare Tapa Wha.

Durie & Kingi (1997) recognized the importance of Te Whare Tapa Whā when discussing the development of a Maori measure of mental health outcome. According to Durie & Kingi (1997), 'measures of outcome are needed to gauge the effectiveness of treatment and care' (p.01). Durie & Kingi completed the development of a Maori mental health outcomes measure to address the need to 'accurately consider Maori perspectives of outcome and Maori approaches to treatment and care' (p.10).

Durie & Kingi (1997) specifically used the four Te Whare Tapa Whā dimensions as the 'core domains of outcome' (p.13) which would be included in the development of a Maori measure of mental health. These domains of outcome were specifically linked to

questions which would assist in measuring the impact and quality of a health intervention for a client. Te Whare Tapa Whā was intentionally selected to provide the domains of outcome for the measure, based on the consistency of the model 'with Maori concepts of health and wellness' (Durie & Kingi, 1997; p.11).

An example of the explicit link between the dimensions of Te Whare Tapa Whā and the Maori mental health outcome is illustrated below in a section of the Tangata Whaiora Assessment Schedule (Durie & Kingi, 1997, p. 70).

Tangata Whaiora Schedule					
Because of the assessment do you feel: (please circle one)					
More valued as a person	Much more	More	No change	Less	Much less
Stronger in yourself as a Maori	Much more	More	No change	Less	Much less
More content within yourself	Much more	More	No change	Less	Much less
Healthier from a spiritual point of view	Much more	More	No change	Less	Much less

To measure the effectiveness of a mental health intervention, the 'Tangata Whaiora Schedule' questionnaires were completed by a client, a person who the client considered as Whanau, and the clients clinician. Following completion of the questionnaire, 'a scoring schedule a numerical score is produced for each respondent. These scores are then compiled and divided by three. The resulting score is then used to provide an indication of the quality of the overall outcome' (p.67).

Durie & Kingi (1997) illustrate how the dimensions of Te Whare Tapa Whā can be synthesized into questions which allow for each dimension of Te Whare Tapa Whā to be explored and measured. Durie & Kingi (1997) provide indicators for responses which correlate to specific dimensions of Te Whare Tapa Wha, as illustrated below in the Maori Outcome Dimension Framework (p.34).

	Domains			
	Wairua	Hinengaro	Tinana	Whanau
Dimension 1	Dignity, respect	Motivation	Mobility/pain	Communication
Dimension 2	Cultural identity	Cognition/ behaviour	Opportunity	Relationships
Dimension 3	Personal contentment	Management of emotions /thinking	Mind and body links	Mutuality
Dimension 4	Spirituality (non-physical experience)	Understanding	Physical health status	Social participation

The indicators outlined above by Durie & Kingi (1997) are of direct relevance when designing a questionnaire to measure the impact of employment in addiction services on addiction practitioners. These indicators provide ways of measuring the phenomena in the definitions of the dimensions of Te Whare Tapa Wha, which contribute to designing questions aimed to identify changes in individual health within each identified dimension of Te Whare Tapa Wha. For example, if participants identify an observed change in their level of personal contentment, this could be attributed to a change in their Wairua, in the Te Whare Tapa Whā model.

Without the development of these indicators, researchers could be at risk of attributing their own perceptions to the definition of each dimension of Te Whare Tapa Whā, rather than Durie's intended attributions which are provided in these indicators. The indicators developed by Durie and Kingi (1997) will be applied within the current research, in both development of the questionnaire and when coding participant responses.

This literature review has provided an overview of the literature that exists which explores the impact of employment in healthcare roles on individual health and wellbeing. Literature reviewed in this section also explores research which has applied Te Whare Tapa Whā in various ways, and in several sectors including education, healthcare and social work.

Chapter Four
Methodology and methods

This chapter outlines and discusses the methodology and research design of this study. This will include an outline of the application of Te Whare Tapa Wha, which is used to methodologically frame the consideration of addiction practitioners' health and wellbeing. Te Whare Tapa Whā also provides a framework to inform the methods of data gathering and analysis through a pragmatic stance. Following this, the identification and rationale for the selection of data gathering methods, and data analysis methods will be provided.

Te Whare Tapa Whā provides a way of thinking about health and wellbeing that underpins the framework for how the individual health and wellbeing of addiction practitioners was measured within this study. Using Te Whare Tapa Whā to provide a methodological framework has guided the development of the research design and methods. The research aimed to consider a pragmatic way to apply Te Whare Tapa Whā and found that application of Te Whare Tapa Whā was supported by a pragmatic stance in relation to the multidimensional consideration of health and wellbeing for individuals.

A pragmatic stance was selected for the study. Pragmatic research does not commit to any one system of reality (Creswell, 2013) and supports approaches which draw from both qualitative and quantitative methods that best meet the research needs and purposes. Instead of focussing solely on fixed research methods, 'researchers emphasize the research problem and use all approaches available to understand the problem' (Creswell, 2013, p.39).

A pragmatic approach involves using a research method which is best suited to the research problem and recognizes that a combination of qualitative and quantitative approaches can be complimentary within the same study (Cherryholmes, 1992; Morgan, 2007; Patton, 1990). The research is centred on understanding addiction practitioner beliefs and behaviours, and the impact of the role of addiction practitioner on these beliefs and behaviours. The study intended to develop a 'theory or pattern of meaning' (Creswell, 2013, p.9), gleaned from open and closed ended questions with both quantitative and qualitative elements. According to Creswell (2013), such approaches typically use a pragmatic stance to underpin study design.

The focus of the study was to understand how addiction practitioners consider their wellbeing has changed since working as a practitioner. It set out to do this by applying the Te Whare Tapa Whā model of health developed by Durie (1984) and using the indicators developed by Durie and Kingi (1997) to identify data related to each dimension of Te Whare Tapa Wha. This research used a questionnaire method, framed by the theoretical model of considering individual wellbeing, provided by Te Whare Tapa Wha.

Methods

This section will describe the data gathering and data analysis methods used for this research, as well as providing a brief rationale for the data gathering and analysis methods used.

Data Gathering

The data gathering method used for this research was a questionnaire. The questionnaire was comprised of a series of primarily closed questions, with some opportunity for open ended responses. The questionnaire administered twenty-two questions. The questions aimed to measure the perceptions of a sample of addiction practitioners in areas relating to their personal health.

The questionnaire invited participants to respond to a series of questions that were developed to explore the four dimensions of Te Whare Tapa Wha, based on the practitioners' perceived sense of wellbeing in each of the four dimensions of Te Whare Tapa Wha. The questionnaire included questions which required practitioners to respond to their perceived levels of physical health, mental/emotional health, spiritual/personal values, and social relationships.

The closed ended questions incorporated a combination of Likert scale and multiple- choice questions. The Likert scale questions were designed to measure phenomenon taken from the indicators of Te Whare Tapa Whā produced by Durie and Kingi (1997). These questions were included to measure participants' feelings and experiences.

The multiple-choice questions were designed to measure practices and behaviours of the sample. Multiple choice questions allowed for practitioners to select from a range of beliefs and behaviours that could be selected by the

practitioner concurrently. This means practitioners may have selected several options at the same time, as illustrated in the question below:

When you feel stressed by your job, do you engage in any of the following? (Check all that apply).

-consuming more caffeine

-smoking

-exercising more frequently

-taking over-the-counter medication

-Taking prescription medication

-consuming more alcoholic beverages

-taking illicit substances

-sleeping more

-eating more

The open-ended questions were designed to allow participants an opportunity to provide further qualitative in-depth description of their experiences.

A questionnaire was chosen as the data gathering method because it allowed for the collection of trends, attitudes and opinions, as well as behaviours and practices of the sample (Creswell, 2013). The aim of this research was to gather trends and attitudes of addiction practitioners. According to Creswell (2013), a questionnaire can provide for a quantitative and qualitative description of trends, attitudes, or opinions of a population by studying a sample of that population. 'From sample results, the researcher generalizes or draws inferences to the population' (p.192).

A questionnaire as a method allowed also for convenience, in terms of ease of

accessibility for respondents, in this case, addiction practitioners in employment. A questionnaire allowed for data to be gathered quickly, and without the need for participants to travel to participate. Creswell (2013) discusses the advantages of questionnaire design in relation to the 'economy of the design, as well as the rapid turnaround in data collection' (p.203). Questionnaires allow for a substantial volume of both qualitative and quantitative responses to be gathered efficiently (Denscombe, 2001) and provide those who choose to participate with an appropriate amount of time to reflect on well considered responses to questions (Wragg, 1999). In this case, given the depth of consideration of personal wellbeing that the questionnaire was setting out to measure, it was deemed important to provide a method in which participants could take the time they needed to reflect on these deeper issues.

Survey Monkey was the data gathering tool used to administer the questionnaire. Survey Monkey is a secure, online data collection tool which allows for the creation and distribution of questionnaires.

Te Whare Tapa Whā as framework for the questionnaire

This section will describe how Te Whare Tapa Whā was applied to the development of questions. Following this, tables will be included to illustrate the specific application of Te Whare Tapa Whā to the questionnaire design.

The questionnaire required participants to answer questions specifically about their wellbeing with emphasis on the period since working in addiction services. This was to ensure findings were directly related as closely as possible to the impact of the role on practitioner wellbeing.

The questionnaire contained a mix of question types. These question types included Likert scale questions, as well as multi-choice and open-ended questions to collect in depth feedback from participants.

The tables below have been developed to show the specific application of Te Whare Tapa Whā to the questionnaire design. The tables provide the definition of each of the four dimensions of Te Whare Tapa Whā as defined by Durie (1984), and then how each pillar aligns to specific indicators of the presence of the dimension identified in this pillar, as identified by Durie and Kingi (1997). For

example, the first row introduces the first dimension of Te Whare Tapa Wha, Te Taha Wairua (spiritual wellbeing). The second row provides the definition of spiritual wellbeing as provided by Durie and Kingi (1997). The first column then provides the measurement indicators that were used to underpin each of the questions and response options in the questionnaire. The second column lists the specific questions that were developed out of the indicators. The final column shows which question type was used to gather the information, i.e. Likert scale, multiple choice or open ended. Presented together in a table form, this aims to show the specific application of the Te Whare Tapa Whā model to the questionnaire design in this research.

Te Taha Wairua (Spiritual Dimension)		
Definition: Spiritual wellbeing. Durie (1998) refers to te taha wairua as the 'capacity for faith and wider communion'.		
Measurement indicators	Related questions	Question type
Spirituality (non-physical experience)	I believe that the work I do: *Has strengthened my relationship with God or a higher power* *Has weakened my relationship with God or a higher power*	Multiple choice
	Since working in addiction services, I have been able to prioritise my spiritual well being. *Yes* *No* *Other (explain)*	Multiple choice
Personal contentment	I believe that the work I do: (Check all that apply) *Gives me a sense of meaning in life Has no relevance or purpose long term*	Multiple choice
	Evaluate the following statements: (Strongly Disagree, Disagree, Agree, Strongly Agree) Since working in addiction services: *I'm feeling inspired and fulfilled by life*	Likert scale

	My life makes sense most of the time *I have become a more accepting person* *I believe people are basically good* *I am a more positive person overall* *I have an improved sense of my own identity*	
Dignity/ respect	A*ny other comments you would like to add regarding how your personal values and spirituality has been affected by working in addiction services?*	Open form
	Any other comments you would like to add regarding your health, wellbeing, and your professional practice?	Open form

Concept: Te taha hinengaro (Mental dimension)		
Definition: Te taha hinengaro refers to thoughts, feelings and behaviour, which are vital to well being. Durie (1998) refers to te taha hinengaro as the capacity to communicate, to think and to feel.		
Measurement indicators	Related questions	Question Type
Management of emotions/ thinking	Since working in addiction services, I have noticed *My mental health has improved* *My mental health has deteriorated* *My mental health has remained the same* *My mental health has fluctuated*	Multiple choice
	Evaluate the following statements: (Strongly Disagree, Disagree, Agree, Strongly Agree) Since working in addiction services: *I been bothered by feeling down, depressed or hopeless* *I feel confident in who I am, and what I must say*	Likert scale

	I feel bothered by little interest or pleasure in doing things	
	Since I started working in an addiction service, I… (Check all that apply) *Experience persistent stress or excessive anxiety in my daily life.* *Have had an anxiety or panic attack.* *Have been diagnosed with a mental health condition*	Multiple choice
	Any other comments you would like to add regarding how your mental health has been affected by working in addiction services?	Open form
Cognition/ behaviour	Evaluate the following statements: (Strongly Disagree, Disagree, Agree, Strongly Agree) Since working in addiction services: *I have become more comfortable expressing my thoughts and feelings*	Likert scale
	Since I started working in an addiction service, I… (Check all that apply) *Have taken prescription medication to manage stress, nervousness, emotional problems or lack of sleep.* When you feel stressed by your job, do you engage in any of the following? (Check all that apply). *Talking to family or friends* *Talking to a medical or mental health professional*	Multiple choice

	Any other comments you would like to add regarding how your mental health has been affected by working in addiction services?	Open form

Concept: Te Taha Tinana (Physical Dimension)		
Definition: Te taha tinana refers to the capacity for physical health and development (Durie, 1998). The physical realm is the most familiar component within the health sector.		
Measurement indicators	Related questions	Question Type
Mobility/pain	Any other comments you would like to add regarding how your physical health has been affected by working in addiction services?	Open form
Opportunity for enhanced health	Since working in addiction services *The foods I eat are more nutritious* *The foods I eat are less nutritious* *The foods I eat are the same as usual* *The pattern fluctuates* *I see my GP more regularly since working in addiction services* *I see my GP less regularly since working in addiction services*	Multiple choice
	Any other comments you would like to add regarding how your physical health has been affected by working in addiction services?	Open form
Physical health status	Since working in addiction services, I have noticed (check all that apply) *My physical health has improved* *My physical health has deteriorated* *My physical health has remained the same*	Multiple choice
	Since working in addiction services *I have gained what I consider to be a significant amount of weight* *I have lost what I consider to be a significant amount of weight*	Multiple choice

	My weight has remained the same *My weight has fluctuated*	
	Any other comments you would like to add regarding how your physical health has been affected by working in addiction services?	Open form
Mind and body links	When you feel stressed by your job, do you engage in any of the following? (Check all that apply). *consuming more caffeine* *smoking* *exercising more frequently* *taking over-the-counter medication* *Taking prescription medication* *consuming more alcoholic beverages* *taking illicit substances* *sleeping more* *eating more*	Multiple choice
	Please check all that apply *I promote the importance of physical health to clients, and I prioritise my physical health.* *I promote the importance of physical health to clients, but I do not prioritise my physical health.* *Working in addiction services helps me sustain my own recovery from addiction* *Working in addiction services makes it difficult for me to sustain my recovery* *I have never had a substance use issue* *I developed a substance use issue while working in addiction services*	Multiple choice

	Any other comments you would like to add regarding how your physical health has been affected by working in addiction services?	Open form

Concept: Te Taha Whanau (Family Dimension)		
Definition: Te taha whānau refers to social well-being. The whānau is the prime support system providing care, not only physically but also culturally, spiritually and emotionally.		
Measurement indicators	Related questions	Question Type
Communication	Since I have been working in addiction services (Please check all that apply) *I have more people with whom I can share what I am really feeling and thinking* *I have less people with whom I can share what I am really thinking and feeling* *I have the same amount of people with whom I can share what I am really thinking and feeling*	Multiple choice
	Any other comments you would like to add regarding how your social life and family relationships have been affected by working in addiction services?	Open form
Social participation	Since working in addiction services *I spend more time with loved ones* *I spend less time with loved ones* *I spend the same amount of time with loved ones*	Multiple choice

	Since I have been working in addiction services (Please check all that apply) *I have enough energy after work to prioritize relationships with others.* *I don't have enough energy after work to prioritize relationships with others.* *I have the same amount of energy after work to prioritize relationships with others.* *I feel an increased sense of belonging socially.* *I feel a decreased sense of belonging socially I have the same sense of belonging socially.*	Multiple choice
	Any other comments you would like to add regarding how your social life and family relationships have been affected by working in addiction services?	Open form

General comments
Throughout the questionnaire, participants were invited to provide any general comments regarding the impact on their professional practice on their wellbeing. Provision of general comments was given as an opportunity after each question.

Sample

The sample size for this study was fifty-three addictions practitioners. This sample was recruited from 600 prospective participants, utilising the total membership of the Drug and Alcohol Practitioners Association of Aotearoa New Zealand (DAPAANZ) registered practitioner list. This list is a publicly available online record of fully registered addiction practitioners in New Zealand.

Inclusion criteria

Inclusion criteria required all participants to be currently registered addiction practitioners who are listed on the DAPAANZ register of practitioners. Any addiction practitioner who is not currently registered, and/or who is not listed on the DAPAANZ register of practitioners was excluded from participation. Current employment as an addiction practitioner is a requirement of addiction practitioner registration.

Recruitment

Potential participants were recruited using a purposive sampling process. Purposive sampling 'focuses on one particular subgroup in which all the sample members are similar, such as a particular occupation or level in an organisations' hierarchy' (Saunders, 2012; p.288). The similarity of the sample members for this study is that they all hold registered practitioner status with the Drug and Alcohol Practitioners' Association Aotearoa. The following steps were followed for the recruitment process:

The researcher developed a web link within Survey Monkey which included an initial information form, an informed consent form, and a link to the research questionnaire. The researcher then sent the web link to each practitioner who had provided a message service on the DAPAANZ website (Appendix Seven). Fourteen days after sending the initial web link, the researcher sent a follow up email to prospective respondents using the same method as the initial link, to remind those who had yet to complete the questionnaire that they had an additional 7 days to do so.

Pilot

The online questionnaire and the participation process were both pretested. This was done by sending a web link to the researcher's academic supervisors via email. This link included all the information that the sample participants would receive. This was to ensure the clarity and comprehension of the questions, and ensure the process operated digitally as it should. The pilot process began one week after receiving approval to proceed from the Weltec Whitireia Postgraduate Board of Studies. Findings from the pilot process were disregarded and excluded from final research findings. The pilot process confirmed that the questionnaire operated effectively, and the questionnaire was approved for sample distribution

by the researcher's academic supervisors.

Data analysis

This section identifies and explains the data analysis methods that were used for this research, how these methods were applied to qualitative and quantitative data, and why they were chosen.

A selection of data analysis methods was used, with the aim of achieving findings of nominal and ordinal measurement, as well as levels of comparative analysis between nominal and ordinal data. The methods of data analysis used included scaled responses which were measured using a Likert scale, frequency analysis, and comparative analysis. Thematic analysis was used to analyse open form comments. Software including Dedoose and Survey Monkey was also used to assist in data analysis. Data analysis methods for the qualitative and quantitative data will be outlined, followed by an explanation of how each method will be applied. A rationale for the two types of data analysis methods used, quantitative and qualitative, will conclude this section.

Quantitative data analysis

The data analysis method used for the quantitative data was descriptive analysis. Descriptive analysis is a method which allows for the data set to be summarized simply, by showing the frequency of responses within a data set, and what could be considered an average response within a sample (Creswell, 2013). Descriptive analysis findings from this study were presented using frequency tables and comparative tables. Frequency tables show the percentage of the sample who responded to each question in a certain way, allowing for generalizations to be made about the sample (Creswell, 2013). Comparative tables allowed for data groups to be considered alongside each other, and compared, for example gender and length of service. To analyse the quantitative data, questionnaire responses needed to be simplified from both the Likert scale and frequency responses.

A Likert scale is a type of question that allows participants to order their level of agreement or disagreement with a statement in a way that most closely reflects their opinion (Burns & Burns, 2008). According to Dawes (2008), Likert scales can be

beneficial when attempting to measure the opinion or attitude of participants in a questionnaire. Likert scales were applied to the development of questions as they allowed for a broader range of responses to be collected than closed 'yes/no' response options would allow for, as illustrated in the example below.

	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
I am feeling inspired and fulfilled by life	22.2% 10	28.9% 13	37.8% 17	11.1% 5

To begin the process of descriptive data analysis, all data gathered from the questionnaire was summarised. This was done by exporting the entire data set from Survey Monkey and creating an Excel spreadsheet which compiled all question responses on a separate Excel page (Appendix Eight).

This process allowed for the identification of any responses which were placed incorrectly (for example, participant gender recorded in the length of service box), and correct these manually. Data summary required the researcher to scan the entire data set repeatedly, to ensure errors in data entry were identified and regrouped. Data summary included cross checking the frequencies and percentage responses provided by Survey Monkey following data corrections.

Following data summary, the creation of custom tables within Excel allowed for exploration, analysis and description of the data. Nominal data (gender/length of service/ethnicity) were compared with ordinal data (ranked answers from Likert scales) to create comparative and frequency tables. These tables were selected as they allow for clear comprehension of the descriptive components of the data set and allow for the impact of employment as an addiction practitioner on health and wellbeing to be seen visually based on the responses of this sample. An example of this type of analysis is seen in the comparative table below.

Relationship between gender and self-perceptions of physical health since being employed in addiction services.			
	My physical health has improved	My physical health has deteriorated	My physical health has remained the same
Male	37.50%	56.25%	25.00%
Female	26.09%	34.78%	26.09%

Descriptive analysis allowed for the data collected within the questionnaire to be arranged and ordered in a way that made interpretation possible. Descriptive analysis also allowed for the common responses of addiction practitioners to be seen and considered in a simple format. The method also aligned closely to the aims of the study, in terms of identifying the frequency of addiction practitioners who identify they are impacted by their roles in certain ways. Descriptive analysis was an appropriate data analysis method for this research, as the aim of this study was to identify and describe 'trends and variation in the sample' (Loeb, 2017).

Qualitative data analysis

The data analysis method selected for the analysis of the open-ended responses in the questionnaire was deductive thematic analysis. Deductive thematic analysis is a data analysis method which focuses on identifying meaning within a data set, as directed by existing concepts or ideas (Braun & Clarke, 2006). This model was used to allow for the four dimensions of Te Whare Tapa Whā to be analysed in terms of how they apply to this sample.

The process of thematic analysis for this study involved the three steps identified by Braun and Clarke (2006, p.87) which are explained in this section. The first step involved becoming familiar with the data, through repeated reading, and the consideration of initial ideas.

The researcher familiarized herself with the data by repeatedly referring to, and reading the data as it arrived in the data collection tool, Survey Monkey. Once all the

questionnaires were completed, all the open-ended responses were collected and organized according to each question number, in an excel spreadsheet. When each spreadsheet was populated completely, the researcher went back and looked at the potential application of the dimensions of Te Whare Tapa Whā as a basis for thematic analysis.

All data were uploaded to Dedoose at this stage. Dedoose is an online data analysis platform. Step two involves the application of initial codes to the data. At this stage, data were reviewed by the researcher within Dedoose, and relevant initial codes (indicators outlined by Durie & Kingi, 1997) were manually attached to data reflecting these indicators. For example, qualitative data referring to a participants' relationship status was attached with the code 'relationships', as this is the name of the indicator provided by Durie and Kingi (1997). An application of the relationships code to a quote can be seen in the following example:

One participant responded to an open form comment opportunity by stating that:

> *'Working with people who have often lost a large connection with their families and loved ones, reinforces for me, the importance of prioritising these relationships'.*

This response, according to the indicators provided by Durie and Kingi (1997), aligned with the 'relationships' indicator, as it speaks about the participants relationships.

Stage three involved reviewing, defining and naming themes. At this stage, once initial codes had been applied, the researcher checked if the dimensions of Te Whare Tapa Whā provided the most relevant way of grouping the entire data set. Once relevance had been determined, the dimensions of Te Whare Tapa Whā were used as the name for each 'theme', and coded data were grouped as indicated in the table below.

Step 1: Indicator code titles	Step 2: Related theme code titles
Mobility/pain Opportunity for enhanced health Physical health status Mind and body links	Taha Tinana (physical wellbeing)
Communication Relationships Social participation	Taha Whanau (Social wellbeing)
Dignity/respect Personal contentment Spirituality (Non-physical experience)	Taha Wairua (Spiritual health)
Management of emotions/thinking Cognition/behaviour	Taha Hinengaro (Mental/emotional health)

Deductive thematic analysis was chosen as the qualitative data analysis method because it allowed for thematic analysis of themes that arose within a data set which related specifically to an already identified thematic framework. In this case, the thematic framework was provided by Te Whare Tapa Wha. Te Whare Tapa Whā presented a collection of themes which considered individual health and wellbeing.

Thematic analysis allowed for responses in the open-ended questions in the questionnaire to be analysed according to the key constructs of a selected theoretical framework, Te Whare Tapa Whā (Stuckey, 2015). The deductive approach to thematic analysis used within this study allowed for data to be explored deeply (Braun & Clarke, 2006) in relation to the dimensions of Te Whare Tapa Wha. Thematic analysis was also a practical approach when considering the size of the sample, as the data set was not prohibitively large; allowing for ample time to thoroughly interpret and code data (Braun & Clarke, 2006; King, 2004).

This research aimed to examine the perspectives of research participants. According to King (2004) thematic analysis is an appropriate tool to summarize the key perspectives of a sample. Thematic analysis was used to illustrate trends and patterns within the frequencies of responses and identify relationships between

these frequencies and identified themes (Mayring, 2000; Pope et al., 2006). Thematic analysis allowed for all variables of the sample, in this case age, length of service, and ethnicity, to be condensed and to allow for cautious correlations to be made between these variables and the dimensions of Te Whare Tapa Whā (Girase, 2007). The use of thematic analysis in this study allowed for essential information to be compared thematically, for instance, the frequency of mental health deterioration between men and women employed in addiction services.

Ethical considerations

Informed consent

Informed consent was requested from all participants once they indicated interest in participating in the online questionnaire. This was to ensure each participant had read and agreed to the information in the information sheet and were aware of how their responses would be used. Informed consent was provided by all research participants, through the following text which was included at the top of the online anonymous questionnaire:

Your participation in this study is entirely voluntary. If you choose to take part, you are free to withdraw from the project at any time, and can withdraw the information provided, without any consequence, before you click 'Submit'.

Please check the box to confirm you are aware that once this questionnaire has been submitted, you will be unable to withdraw the information you have provided □

Please check the box to confirm that you have read the Information Sheet about this research project, and understand what it is about □

I agree to take part in the study □

Informed consent was required before participants could begin the questionnaire. The questionnaire was designed to ensure that respondents could only proceed to complete the questionnaire if they ticked the box to agree to take part.

Potential harm or discomfort to participants or researchers

As this research sought to understand the factors impacting on addiction

practitioners, there was potential for strong emotions to be evoked for participants when reflecting on their own experiences. The information sheet and consent form provided the required information to inform participants of their right to cease participation. The information sheet also provided information about support agencies that participants could access.

To minimise potential discomfort for the researcher, the researcher kept a reflective research journal and accessed the support of her academic supervisors. The journal was used as a reflective tool to record any questions/thoughts the researcher wished to seek guidance from her supervisors about.

Conflicts of interest

The researcher was aware of possible conflict of interest arising because of the generally small size of the total population of addiction practitioners in New Zealand. Potential conflict of interest issues included the exploration of practitioner wellbeing, where the practitioners may have been colleagues of the researcher at some stage. This was managed by the researcher explaining in the information sheet, ensuring that all participants were aware of the identity of the researcher and the researcher's academic supervisors before consent to commence the questionnaire. The researcher also ensured the identity of participants was protected using an anonymous online questionnaire, which required no personal information to be submitted.

Privacy, anonymity and confidentiality

There was potential for breach of confidentiality due to the size of the New Zealand population and the limited number of addiction agencies. Although the feedback received and collated would not be easily identifiable, the information provided about working environments in the open questions in the questionnaire may have been sensitive.

Participants were informed at the consent stage that their personal information and data would be password protected. Survey Monkey was the primary data gathering tool, where participants had access to a unique link and could respond to questions without providing any identifiable information. Because the information collected was collated into themes and anonymized, there was low risk of privacy and

confidentiality being breached.

The anonymity of the participants was maintained as only information that participants were comfortable sharing was used, and any identifiable features of open ended feedback were removed. Throughout the data analysis stage, the researcher repeatedly reviewed all data gathered and removed all data that could identify a participant. For example, the researcher removed the email addresses of participants who wished to be informed of the research outcomes, before collected data was included in this thesis document.

The data collected was stored within the Survey Monkey tool, for the period of the completion and examination of this project. The data collected was stored with three-way password protection. The initial password was the login to the researchers' PC; the second password being the login to the researcher's email; the third password being the login to Survey Monkey data. During data collection, data was stored electronically through an anonymized cloud provided by the Survey Monkey server. Only the researcher had access to this.

Representativeness

This section provides an overview of the representativeness of the research sample. In doing this it also considers some demographic criteria of research participants, including their ethnicity and gender. The final sample size of 53 was recruited from a prospective population of 600 registered practitioners. This represents a response rate of 8.83 per cent.

In terms of other demographic considerations such as gender and ethnicity and years of service, the recruitment did not set out to purposefully sample on these criteria. Therefore, it is not possible to make statements of representativeness of these criteria. Having said this, the distribution of responses reflects that gender was a consideration in the distribution of responses. Of the 53 who responded in total, 58.97% were women.

The sample was mainly representative of New Zealand European females who had been employed as addiction practitioners for over five years. Men were represented at only a slightly lower rate than women, with non-binary participants not represented at all, due to no participants identifying as non-binary. Maori constituted one quarter

of the sample. with a sample size which allowed for the impact of employment as an addiction practitioner to be seen across each dimension of Te Whare Tapa Wha.

Although some trends were evident as a result of this sample data, future research will be required with a larger sample of registered practitioners to confirm and validate these themes.

Researcher Reflections

Before commencing this research, I was concerned about the appropriateness of engaging with Te Whare Tapa Whā for framing and considering addiction practitioner health and wellbeing, as a non-Maori researcher. Although my own core beliefs about health and wellbeing were encapsulated by Te Whare Tapa Wha, I felt some sense of reservation about applying the model without explicit permission from Maori. These concerns were reflected somewhat in the feedback from the Postgraduate Board of Studies (Appendix Four) in response to submission of the research proposal for approval.

The Board requested that I provide evidence of guidance sought regarding understanding and use of Maori philosophy and concepts. This recommendation, and my own response, have been included as Appendix One and Two. The researcher's considerations and suggestions were approved by the Postgraduate Board of Studies (Appendix Three). Cultural supervision was a key factor in the development of my confidence in applying Te Whare Tapa Wha.

My cultural supervisor encouraged the use of Te Whare Tapa Whā in this study and allowed me to see the benefits of applying a New Zealand model to New Zealand practice. The process of cultural supervision challenged me to explore my own beliefs in more depth and encouraged me to 'trust my gut' and seek permission from tangata whenua to apply Te Whare Tapa Whā in this research. Gaining explicit permission to apply Te Whare Tapa Whā was not required to progress with this research, however I felt compelled to do so in acknowledgement of what has been taken from Maori unjustly in New Zealand historically (Durie, 1994; Ministry of Culture and Heritage, 2017; Pool, 1991).

I had the opportunity to meet Mason Durie during the Asia Pacific Suicide Prevention Conference, held at Waitangi Treaty Grounds in May 2018. This was a significant

memory for me. Mason was sitting at a cafe after presenting to the conference group. I wondered if he might be annoyed by a beginning researcher who was almost too nervous to string a sentence together interrupting his moment of peace. The response I got when I asked for a moment of his time was humbling. He invited me to take a seat and listened while I shared what I was trying to achieve with my research. He asked questions about how Te Whare Tapa Whā would be applied and gave me his permission to apply Te Whare Tapa Whā to my research. Crying in front of your heroes will always be embarrassing, but a weight lifted off my shoulders knowing that permission had been granted.

Another consideration requiring reflection was my own beliefs about the impact of employment as an addiction practitioner on health and wellbeing. These beliefs had formed during my employment as an addiction practitioner. During my employment, I had engaged in conversations with my colleagues, as well as referrers and the staff I managed. It was difficult to manage my own perceptions when reflecting on the data gathered during the research process. Insider research can lead to challenges around managing researcher assumptions. Allowing the data to speak for itself took a concentrated effort, as there were data that challenged my own impressions at times.

The value of the clearly defined indicators provided by Durie and Kingi for Hua Oranga (1997) was huge. Using these indicators, I could code data in a way that allowed for my own perceptions to comfortably sit outside what the data was saying in relation to the Hua Oranga indicators; and for me as a practitioner to reflect further on my own assumptions. For future research, I would be likely to analyse data less deductively, however, I now value deductive analysis as a good option for researchers who have a lived experience of the population they are researching.

The research process has increased my motivation for further research. I have learned the contribution it can make, as well as what my research may be lacking. I have learned that I will never view my research as ‘finished’, which is equal parts frustrating and inspiring. I know what I would do differently next time, as well as what my strengths and weaknesses are as a researcher.

Summary

This chapter has described the methodology and its rationale to inform the study

design. It has then outlined and described the methods of data gathering, data analysis, and ethical considerations that underpinned the study. The researchers own reflections were also included. The next chapter will outline the qualitative and quantitative findings of the study.

Chapter Five
Findings

The following section outlines the quantitative and qualitative findings of this study. It will do this by summarizing the findings for the questionnaire using frequency and comparative analysis tables, followed by a brief written summary of the data collected in each question. Response rates are shown for each question in the questionnaire. Not all participants responded to all the questions, therefore percentages reported correspond to the total number of responses for each question. Some questions allowed for multiple answer options to be selected, therefore percentages reported correspond to the total number of selections for each available response. An example of this is seen in question four, where the total frequency of responses is 222%. This is because participants selected multiple options, to answer this question.

Question 1: Number of years of practitioner experience

Answer Choices	Frequency
1 year or less	19.51%
Over 1 year, up to 3 years	21.95%
Over 3 years, up to 5 years	14.63%
Over 5 years, up to 10 years	29.27%
Over 10 years, up to 15 years	9.76%
Over 15 years	4.88%

Length of experience was tabulated, and participants were asked to tick the relevant option provided. A 77% response rate was achieved, with 12 participants skipping this question. Most practitioners within this sample reflected that they had been practising for over 5 years, and up to 10 years, with the smallest number of practitioners practicing for over 15 years.

Question 2: Optional gender identity question

Answer Choices	Frequency
Male	41.03%
Female	58.97%
Non- binary	0.00%

Question 3: Ethnicity

Open form responses:	
Maori	15.38%
Pakeha	7.69%
New Zealand European	38.46%
Caucasian	19.23%
Italian	3.85%
Irish	3.85%
White	3.85%
Kiwi	3.85%
New Zealand Pakeha	3.85%

Participants were given the option to state their ethnic identity according to their own choice, rather than a predetermined set of options. In this way, the question was open form. Over one third of participants identified as New Zealand European (38.46%).

Pākehā as a self-selected choice constituted less than 10% of the sample (7.69%). Therefore, the total responses from New Zealand European and Pākehā combined were 46%, followed by Caucasian (19.23%) and Maori (15. 38%). If Caucasian is included with New Zealand European and Pākehā, the total responses from this group is 65%, thereby constituting nearly two thirds of the total sample. There were equal responses from self-identified Italian, Irish, Kiwi, New Zealand Pākehā and White practitioners.

Question 4: Since working in addiction services, I have noticed (Check all that apply)

Answer Choices	Frequency
a change in my physical health	54.00%
a change in my mental health	66.00%
a change in my personal values or spiritual beliefs	56.00%
a change in my social or family life and relationships	46.00%

Changes in mental health were found to be the most common changes in wellbeing identified, with 66% of participants indicating that they felt their mental health had changed since working in addiction services. Changes in personal values and spiritual beliefs followed at 56%, with changes in physical health (54%) and social wellbeing (46%) also reflected as common among this sample.

Question 5: Since working in addition services, I have noticed (Check all that apply)

Answer Choices	Frequency
my physical health has improved	28.00%
my physical health has deteriorated	44.00%
my physical health has remained the same	28.00%

Fifty practitioners responded to this question (94.3%). Out of these, 44% identified they had noticed a deterioration in their physical health since working in addiction services. 28% noted that their physical health had improved, and 28% indicate that their physical health had remained the same.

Question 6: Since working in addiction services (Check all that apply)

Answer Choices	Frequency
I have gained what I consider to be a significant amount of weight	32.00%
I have lost what I consider to be a significant amount of weight	34.00%
my weight has remained the same	26.00%
my weight has fluctuated	20.00%

This question aimed to measure if and how practitioners describe patterns in their weight since working in addiction services. 94.3% of participants responded to this question. 32% of practitioners had gained what they consider to be a significant amount of weight since working in addiction services. 34% had lost what they consider to be a significant amount of weight. 26% noted that their weight has remained the same, with 20% perceiving that their weight fluctuates.

Question 7: Since working in addiction services (Check all that apply)

Answer Choices	Frequency
the foods I eat are more nutritious	18.75%
the foods I eat are less nutritious	54.17%
the foods I eat are the same as usual	16.67%
the pattern fluctuates	16.67%

54.1% of participants indicated that the foods they eat are less nutritious since working in addiction services. 18.7% note that the foods they eat are more nutritious, with 16.6% percent of participants noting that the nutritional value of the foods they eat has remained the same as usual since working in addiction services. 16.6% of participants also reflected that the pattern of nutritional value in the foods they consume fluctuates.

Question 8: When you feel stressed by your job, do you engage in any of the following? Check all that apply.

Answer Choices	Frequency
consuming more caffeine	54.17%
consuming less caffeine	2.08%
smoking	25.00%
exercising more frequently	31.25%
exercising less frequently	25.00%
taking over-the-counter medication	14.58%
taking prescription medication	29.17%
consuming more alcoholic beverages	37.50%
consuming less alcoholic beverages	0.00%
taking illicit substances	25.00%
sleeping more	22.92%
sleeping less	18.75%
eating more	31.25%
eating less	14.58%
talking to family or friends	16.67%
talking to a medical or mental health professional	16.67%

48 out of 53 participants chose to respond to this question, with participants having the opportunity to check all responses that applied to them.

The five most prevalent practices identified by practitioners to represent what they do when feeling stressed by their job are: consuming more caffeine (54.17%), consuming more alcoholic beverages (37.5%), exercising more frequently (31.25%), eating more (31.25%), and taking prescription medication (29.17%).

Question 9: Please check all that apply

Answer Choices	Frequency
I promote the importance of physical health to clients, and I prioritise my physical health	29.17%
I promote the importance of physical health to clients, but I do not prioritise my physical health	52.08%
Working in addiction services helps me sustain my own recovery from addiction	27.08%
Working in addiction services makes it difficult for me to sustain my recovery	12.50%
I have never had a substance use issue	8.33%
I developed a substance use issue while working in addiction services	8.33%
I see my GP more regularly since working in addiction services	29.17%
I see my GP less regularly since working in addiction services	8.33%

Over half (52.08%) of practitioners reflected that they promote the importance of physical health to clients, but do not prioritise their own physical health. The relationship between a practitioner's own potential recovery from addiction and working as an addiction practitioner was explored. Some insight regarding this relationship can be observed with over one quarter (27.08%) of practitioners reflecting that working in addiction services helps them sustain their own recovery from addiction. 29.17% of practitioners identified that see their General Practitioner more regularly since working in addiction services.

Question 10: Since working in addiction services, I have noticed (Check all that apply)

Answer Choices	Frequency
my social or family life and relationships have improved	12.24%
my social or family life and relationships have deteriorated	51.02%
my social or family life and relationships have remained the same	32.65%

When asked about general changes in their family life and relationships since working in addiction services, 51.02% of practitioners responded that their family life and relationships have deteriorated. 32.65% responded that their family life and relationships have remained the same, and 12.24% noted that their family life and relationships have improved. 49 practitioners responded to this question, and 4 practitioners did not respond.

Question 11: Since working in addiction services (check all that apply)

Answer Choices	Frequency
I spend more time with loved ones	27.45%
I spend less time with loved ones	43.14%
I spend the same amount of time with loved ones	27.45%

Participants were asked to respond to self-perceived changes in their social wellbeing. Social wellbeing questions included exploration of biological family relationships, romantic and social relationships, as well as support structures including loved ones (as defined by the practitioner themselves), and other people who matter to the practitioner. When asked about time spent with loved ones since working in addiction services, 43.14% noted that they spend less time with loved ones. 27.45% of practitioners responded that they spend more time with loved ones since working in addiction services. 27.45% of practitioners responded that they are spending the same amount of time with loved ones since working in addiction services.

Question 12: Since working in addiction services (Check all that apply)

Answer Choices	Frequency
I have started a significant romantic relationship or marriage	22.45%
I have ended a significant romantic relationship or marriage	51.02%
my relationship status has remained the same	28.57%

There was a 92% response rate for this question. 51.02% of participants responded that they had ended a significant relationship or marriage since working in addiction services. 22.45% of participants responded that they have started a romantic relationship or marriage since working in addiction services. 28.57% noted that their relationship status has remained the same.

Question 13: Since I have been working in addiction services (Check all that apply)

Answer Choices	Frequency
I have enough energy after work to prioritize relationships with others	16.33%
I don't have enough energy after work to prioritize relationships with others	51.02%
I have the same amount of energy after work to prioritize relationships with others	12.24%
I feel an increased sense of belonging socially	4.08%
I feel a decreased sense of belonging socially	32.65%
I have the same sense of belonging socially	22.45%

Despite the noted deterioration of relationships, less time spent with loved ones and ending of significant relationships and marriage, 27.66% of practitioners' state that they feel the same level of care from people who matter to them. 25.53% of practitioners feel they are less cared about by people who matter to them, with 17.02% feeling more cared about by people who matter to them. These responses are captured in the table below.

Question 14: Since I have been working in addiction services (Check all that apply)

Answer Choices	Frequency
I feel I am more cared about by people who matter to me	17.02%
I feel I am less cared about by people who matter to me	25.53%
I feel the same level of care from people who matter to me	27.66%
I have more people with whom I can share what I am really feeling and thinking	14.89%
I have less people with whom I can share what I am really feeling and thinking	44.68%
I have the same amount of people with whom I can share what I am really thinking and feeling	8.51%

Over one quarter of the sample reflected that they feel less cared about by people who matter to them, since working in addiction services. 44.68% feel they have less people with whom they can share what they are really thinking and feeling.

Question 15: Since working in addiction services, I have noticed

Answer Choices	Frequency
my mental health has improved	14.58%
my mental health has deteriorated	45.83%
my mental health has remained the same	12.50%
my mental health has fluctuated	27.08%

Mental health deterioration since working in addiction services was identified by nearly half (45.83%) of participants. The next most frequent response was in relation to what practitioners perceive as fluctuations in their mental health since working in addiction services (27.08%).

Question 16: Since working in addiction services

	Strongly disagree	Disagree	Agree	Strongly agree
I have become more comfortable expressing my thoughts and feelings	12.77%	31.91%	38.30%	17.02%
I have been bothered by feeling down, depressed or hopeless	14.58%	27.08%	31.25%	27.08%
I feel confident in who I am, and what I have to say	21.28%	19.15%	44.68%	14.89%
I feel bothered by little interest or pleasure in doing things	19.15%	29.79%	38.30%	12.77%

The majority of addiction practitioners either agree or strongly agree that they feel more confident in who they are, and what they have to say since working in addiction services (59.57%). The next most frequent response was in relation to practitioners being bothered by feeling down, depressed or hopeless since gaining employment in the field (58.33%). Over half (55.32%) of participants agree that they have become more comfortable expressing their thoughts and feelings since working in addiction services. Over half (51.07%) of participants observed that they feel bothered by little interest or pleasure in doing things since working in addiction services.

Question 17: Since I started working in an addiction service, I .... (Check all that apply)

Answer Choices	Frequency
experience persistent stress or excessive anxiety in my daily life	48.84%
have taken prescription medication to manage stress, nervousness and emotional problems or lack of sleep	48.84%
have had an anxiety or panic attack	25.58%
have been diagnosed with a mental health condition	16.28%

Equal response rates (48.84%) were expressed by the sample when noting that since working in addiction services, stress. nervousness, emotional problems and

anxiety were experienced. Over quarter of participants have had an anxiety or panic attack since working in addiction services, with 16.28% indicating that they have been diagnosed with a mental health condition since working in the field.

Question 18: I believe that the work I do (Check all that apply)

Answer Choices	Frequency
gives me a sense of meaning in life	53.06%
has no relevance or purpose long term	10.20%
has strengthened my relationship with my religion	40.82%
has weakened my relationship with my religion	8.16%

Participants were invited to respond to how they perceive the work they do affects their sense of meaning in life, as well as the impact on their relationship with their religion. Over 53% of participants responded that their role gives them a sense a meaning in life. 40.82% of practitioners reflected that the work they do has strengthened their relationship with their religion. Low rates of response (10.2% and 8.16% respectively) believe that the work they do has no relevance or purpose long term or has weakened their relationship with their religion.

Question 19: Since working in addiction services

	Strongly disagree	Disagree	Agree	Strongly agree
I am feeling inspired and fulfilled by life	22.22%	28.89%	37.78%	11.11%
my life makes sense most of the time	21.74%	28.26%	43.48%	6.52%
I have become a more accepting person	15.22%	26.09%	47.83%	10.87%
I believe people are basically good	17.78%	28.89%	42.22%	11.11%
I am a more positive person overall	13.04%	34.78%	39.13%	13.04%
I have an improved sense of my own identity	4.35%	43.48%	43.48%	8.70%

58.70% of participants either agree or strongly agree that they perceived they have become a more accepting person since working in addiction services. 53.33% believe that people are basically good, with 52.17% finding that they have become a more positive person overall since working in addiction services. Over half (52.18%) of practitioners also find that they have an improved sense of their own identity since working in addiction services.

Question 20: Since working in addiction services, I have been able to prioritise my spiritual well being

Answer Choices	Frequency
No	50%
Yes	50%

Practitioners were invited to share if they had been able to prioritise their spiritual wellbeing since working in addiction services. Responses were evenly split, with 50% responding yes, and 50% responding no.

Question 21: Any other comments you would like to add regarding how your personal values and spirituality have been affected by working in addiction services?

The work I do has meaning to me, and it is rewarding to see people recover. Recovery improves my faith, I struggle with clients who relapse when I think of a God who is good, especially when those clients have children and families. Sometimes I wish God would just 'step in' But I also understand free will. That is the challenge for me, wanting God to act but knowing the client has to do the work.

I have learned the value of every little interaction. Everything you say can affect another person, you have to be so careful with people because you never know what could hurt them. I still have a strong faith in God, I just understand him less since working in addiction.

No

They have become much more real and central to my living life to the fullest.

I am a person with extreme compassion and empathy. I'm VERY easily manipulated.

For me the journey to this vocation has always been to reinforce my recovery
this includes the spiritual and ongoing education required.
Step 12 values are more important
No
I have become more Cynical
No

Question 22: Are there any other comments you would like to add regarding your health, wellbeing and your professional practice?

Interesting to be asked about my own well-being when generally we only think about how the clients are doing

You really can't separate who you are from the work you do in addictions. If you are angry, the clients will know about it. If you are sad, they try to take care of you. If you don't look after yourself, you can't look after your clients properly. I have noticed that I am far more conscious of my own wellbeing since working in the addiction field.

No

My health wellbeing and professional practice has become strongly aligned.

No

No

My health and wellbeing are borderline fair.

I have always maintained a strict boundary between my work commitments in order to not suffer any mental health issues.

No

Addiction services screw you over due to politics & idiots. Not valued for your actual work

No

Sometimes I don't know if it is my professional practice that is linked directly to my wellbeing, or other aspects of life.

Became increasingly difficult to stay healthy and enthusiastic.

No

Open ended comments section responses (Qualitative data findings).

The following section provides the complete list of comments that have been provided for each of the open-ended questions, as well as coded frequency analysis from the data analysis software, Dedoose. Comments provided by practitioners have not been altered or edited. It is included to illustrate the volume of comments that relate to each dimension of Te Whare Tapa Wha.

Open form comment code application rates from Dedoose

Comment has indicators that relate most closely to:	Total code applications	Percentage of total open form responses
Taha Tinana	16	30.18%
Taha Whanau	8	15.09%
Taha Wairua	13	24.52%
Taha Hinengaro	16	30.18%
Total open form responses	53	

The following table presents the indicators present in each comment, which have allowed for coding to each dimension of Te Whare Tapa Wha. The table is included to allow for transparency in relation to the allocation of codes to comments.

Taha Tinana: Physical Health		
Indicators for coding to physical wellbeing.	Comments relating to each indicator	Percentage of total responses related to this indicator
Mobility/pain	Once I realised the sedentary nature of the work. I was able to adjust my diet to suit. The role is far more sedentary than my previous work. I think this is a key cause of the weight gain.	12.5%
Opportunity for enhanced health	I exercise every weekday now. I think because I need it to clear my head before work, it helps me feel in control of my day. I am careful about what I eat now. Due to unhealthy initial toxic work situation, my health deteriorated markedly. Since the work situation has changed my health has improved, but a lot of damage was done that has repercussions for the rest of my life. Much more aware of the nutritious quality of my food and drinks.	25%
Physical health status	I regularly feel tired/depleted of energy. I feel like a liar if I don't keep fit, but always tell my clients to keep fit. I have gained weight. I work out, nothing to do with job. So many meetings, so much cake. Food provided within services were allocated to us also and these were terrible foods.	37.5%
Mind and body links	I have less sleep, I feel worried about the job. I have less energy. I started using amphetamine in the weekends only. It gave me energy to get things done, because I was so tired from the working week. I don't think I have developed an addiction, I just feel it helps me get the most out of my week.	25%

Taha Whanau: Social health		
Indicators for coding to social wellbeing	Comments relating to each indicator	Percentage of total responses related to this indicator
Communication	As I am continually teaching and talking about communication skills with my clients, I have noticed that I am increasingly aware of the way I communicate. This has made me far more conscious of the words I say, and why I react the way I do. Thoughts leading to feelings and actions has influenced the way I choose to respond. They (other people) don't understand the work I do, so conversations can get a bit awkward because of their judgements around addicts.	25%
Relationships	Working with people who have often lost a large connection with their families and loved ones, reinforces for me, the importance of prioritising these relationships. I'm not in a romantic relationship. (In response to the question 'I have ended a significant relationship or marriage). Yeah but he was an arsehole anyway. Probably would've left sooner if I was still a black & white thinker.	37.5%

Taha Wairua: Spiritual health		
Indicators for coding to spiritual wellbeing	Comments relating to each indicator	Percentage of total responses related to this indicator
Dignity, respect	Very difficult to have faith in your voice working in this field. There is quite intense criticism of what is said in group sessions and 1-1 sessions, and ongoing bad feedback can crush your confidence in the work you do. It would be great for new practitioners if their supervisors supported them rather than continually talking about the risk of what they have said wrong, you start feeling scared to say anything at all to clients.	7.69%
Personal contentment	The work I do has meaning to me, and it is rewarding to see people recover. Recovery improves my faith, I struggle with clients who relapse when I think of a God who is good, especially when those clients have children and families. Sometimes I wish God would just 'step in' But I also understand free will. That is the challenge for me, wanting God to act but knowing the client has to do the work. I hope I am making a difference. 12 Step values are more important. Cynical and disillusioned to some degree. I shut down more.	38.46%
Spirituality (Non- physical experience)	Loss of faith in God after seeing how badly people get treated. My beliefs have become much more real and central to my living life to the fullest. For me the journey to this vocation has always been to reinforce my recovery this includes the spiritual and ongoing education required. I pray more, because I need to. I try to keep my spiritual beliefs out of my work. The struggles that people go through have also affected my faith, in terms of the whole 'if God was all powerful then why does he allow	61.53%

	suffering' kind of thinking. I have learned the value of every little interaction. Everything you say can affect another person, you have to be so careful with people because you never know what could hurt them. I still have a strong faith in God, I just understand him less since working in addiction. I feel a loss in terms of my relationship with God, it's hard to connect with a God who could ease suffering, but doesn't. It's hard to imagine that because of an adult's free will, a child might be neglected or abused. Really hard to understand how god doesn't act or protect the vulnerable when it is within his power to do so. The work challenges your faith.	

Taha Hinengaro: Emotional/mental health		
Indicators for coding to Taha Hinengaro	Comments relating to each indicator	Percentage of total responses related to this indicator
Management of emotions, thinking	Doubting my self-worth and competence in the job. I have learnt HEAPS about keeping myself mentally healthy. Always stressed about my clients and I feel too responsible for them. Due to the high level of responsibility I feel for my clients. I feel like if they lapse, it's my fault. If anything at all goes wrong for them, I question what I could have done differently to stop it from happening. It's exhausting. My health and wellbeing are borderline fair. Addiction services screw you over due to politics & idiots. Not valued for your actual work.	62.5%

	Depression due to non-clinical management. I developed depression, which I require antidepressants for. I developed insomnia. Sleeping tablets - I have seen my GP to get these when work stress has been severe. Sometimes I don't know if it is my professional practice that is linked directly to my wellbeing, or other aspects of life.	
Cognition/ behaviour	Doubting my self-worth and competence in the job. I have learnt HEAPS about keeping myself mentally healthy. Always stressed about my clients and I feel too responsible for them. Due to the high level of responsibility I feel for my clients. I feel like if they lapse, it's my fault. If anything at all goes wrong for them, I question what I could have done differently to stop it from happening. It's exhausting. My health and wellbeing are borderline fair. Addiction services screw you over due to politics & idiots. Not valued for your actual work. Depression due to non-clinical management. I developed depression, which I require antidepressants for. I developed insomnia. Sleeping tablets - I have seen my GP to get these when work stress has been severe. Sometimes I don't know if it is my professional practice that is linked directly to my wellbeing, or other aspects of life.	37.5%

	I am a person with extreme compassion and empathy. I'm VERY easily manipulated. You really can't separate who you are from the work you do in addictions. If you are angry, the clients will know about it. If you are sad, they try to take care of you. If you don't look after yourself, you can't look after your clients properly. I have noticed that I am far more conscious of my own wellbeing since working in the addiction field. My health wellbeing and professional practice has become strongly aligned. I have always maintained a strict boundary between my work commitments in order to not suffer any mental health issues. Interesting to be asked about my own well-being when generally we only think about how the clients are doing. Became increasingly difficult to stay healthy and enthusiastic.	

Correlations between the demographic data and health variables is presented below. This information is included as it assists in informing the summary of key points which is included in the discussion of findings.

Length of service as an addiction practitioner and changes in health

Length of service	Deterioration in physical health	Deterioration in social or family life	Deterioration in mental health
1 year or less	42.86%	42.86%	37.50%
Over 1 year, up to 3 years	33.33%	66.67%	33.33%
Over 3 years, up to 5 years	50.00%	50.00%	83.33%

Over 5 years, up to 10 years	25.00%	33.33%	63.64%
Over 10 years, up to 15 years	75.00%	100%	25%
Over 15 years	50%	50%	0.00%

Findings from this data reflect that the highest rates of deterioration in physical and social wellbeing are seen in practitioners who have been practicing for over 10 years. Highest rates of deterioration in mental health are seen in practitioners who have been practicing for over 3 years and up to five years.

Relationship between gender and self-perceptions of physical health since being employed in addiction services.			
	My physical health has mproved	My physical health has deteriorated	My physical health has remained the same
Male	37.50%	56.25%	25.00%
Female	26.09%	34.78%	26.09%

Males from this sample are more likely than females from this sample to experience what they perceive as fluctuations in their physical health because of employment in addiction services.

Relationship between gender and self-perceptions of mental health since being employed in addiction services.				
	My mental health has improved	My mental health has deteriorated	My mental health has remained the same	My mental health has flucated
Male	18.75%	43.75%	12.50%	25.00%
Female	13.64%	50.00%	9.09%	27.27%

Females are more likely than males to experience deterioration and fluctuation in their mental health as a result of employment in addiction services. Males from this sample are slightly more likely to experience an improvement in their mental health as a result of employment in addiction services.

Chapter Six
Discussion

Employment as an addiction practitioner can have an impact on the physical, mental, social and spiritual wellbeing of an individual. This chapter will discuss the meaning and importance of the findings. The dimensions of Te Whare Tapa Whā will be applied as a framework for understanding individual physical, mental, emotional and spiritual wellbeing of addiction practitioners. Following this, a summary of key points exploring the wellbeing of the sample of novice to experienced addictions practitioner will be provided.

The summary of key points highlights patterns of change in health and wellbeing over the course of time in employment for the addiction practitioners in this sample. The summary was developed to assist in exploring possible supports that could be implemented throughout an addiction practitioner's career.

Dimension 1: Taha Hinengaro (Mental wellbeing).

Overarching themes emerged from the findings, which indicate the sample's perceptions of changes in their personal wellbeing during their time in employment as an addiction practitioner.

Most of these practitioners identify deterioration in their mental health since starting employment, an increase in feelings of hopelessness and depression, as well as the use of medication to manage mental health symptoms. The volume of qualitative comments from questionnaire participants relating to stress, depression, the use of medication to manage stress, and feeling high levels of responsibility for clients, support this finding. It is noted that most of the qualitative comments indicate that practitioners feel their mental health has deteriorated in response to stress related to their role of addiction practitioner.

58.33% of participants indicated that they have been bothered by feeling down, depressed or hopeless since being employed as an addiction practitioner. Responses to the open-ended questions support this finding, with practitioners repeatedly expressing the impact of the stress of the role on their mental health. Open ended responses relating to this finding include the following:

-*I have less sleep, I feel worried about the job. I have less energy.*

-Due to (an) unhealthy initial toxic work situation, my health deteriorated markedly. Since the work situation has changed my health has improved, but a lot of damage was done that has repercussions for the rest of my life.

Further to this, participants from this sample outlined many stress responses including illicit substance use, increased use of alcohol, and decreased engagement with loved ones. These responses were unanticipated in relation to the perception that professionally registered health workers would have an understanding and ability to manage their own wellbeing. These responses support the rationale for increased self- care planning at the initial stages of addiction practitioner training.

After reviewing literature examining the mental wellbeing of healthcare workers in broader healthcare fields such as nursing, aged care and palliative care, moderate responses indicative of stress were reflected. According to Brunero, Duffield, Gallagher Lamont, & Perry (2015), nurses are approximately three times more likely than the general population to experience depression.

Dimension 2: Taha Wairua (Spiritual wellbeing).

Spirituality was indicated by practitioners in this study to have been impacted since commencing employment in addiction services. This was identified in both the quantitative and qualitative responses. Over 60% of free form comments relating to spirituality illustrate the complexity of maintaining a relationship or connection with a higher power when considering client suffering. Questionnaire responses support this and show that addiction practitioners identify they feel like the work they do contributes to their sense of purpose and meaning in life.

Examples of the difficulty in maintaining a relationship with a higher power when working in addiction services can be seen in the following comments:

- *I feel a loss in terms of my relationship with God, it's hard to connect with a God who could ease suffering, but doesn't. It's hard to imagine that because of an adult's free will, a child might be neglected or abused. Really hard to understand*

how god doesn't act or protect the vulnerable when it is within his power to do so. The work challenges your faith.

- *I have learned the value of every little interaction. Everything you say can affect another person, you have to be so careful with people because you never know what could hurt them. I still have a strong faith in God, I just understand him less since working in addiction.*

The majority (80%) of participants who responded that they believe that the work they do has no relevance or purpose long term also identified that they experienced a deterioration in their physical health since working in addiction services. In contrast, a significantly lower rate (34.6%) of practitioners who believed the work they do gives them a sense of meaning in life experienced a deterioration in their physical health.

38.9% of New Zealand European practitioners believe the work they do gives them a sense of meaning in life, compared to 11.1% of Maori. No comments were provided which assisted in understanding this difference in more detail. Females experienced significantly greater sense of meaning in life than males, with 71.4% of females reporting that the work they do gives them a sense of meaning in life, compared to only 28.6% of males. Those who had been employed for over 5 years as an addiction practitioner noted the highest sense of meaning in life, at 36.4%, with the lowest sense of meaning in life seen in practitioners who had been practicing for over 10 years (4.5%).

Employment as an addiction practitioner, according to this sample, has an impact on the spiritual wellbeing of an individual. This is not to say that employment as an addiction practitioner is the only contributing factor to the impact on spirituality, as other environmental impacts were not specifically requested, but the practitioners in this study identified changes in their spiritual wellbeing since employment as addiction practitioners.

This is in keeping with the findings which show that over 60% of free form comments relating to spirituality illustrate the complexity of maintaining a relationship or connection with a higher power when considering client suffering. Literature regarding spiritual wellbeing in healthcare services is heavily weighted toward the spiritual wellbeing of people who access healthcare services. As there is limited

literature considering the spiritual wellbeing of healthcare practitioners, this research serves as a starting point for discussion when considering how to promote the importance of this component of wellbeing in addiction practitioners.

Dimension 3: Taha Whanau (Social wellbeing).

When reviewing data relating to whanau, both quantitative and open form responses support and expand upon each other with the Taha whanau domain. In addition to the deterioration of relationships, less time with loved ones was experienced by most participants, and these core themes are reflected similarly by both data sets.

Participants were asked to respond to changes in their social wellbeing. Social wellbeing questions included exploration of biological family relationships, romantic and social relationships, as well as support structures including loved ones (as defined by the practitioner themselves), and other people who matter to the practitioner.

Both qualitative and quantitative data sets reflected social isolation as a result of commencing employment as an addiction practitioner. 50% of open form comments identify the impact of the role on decreased social isolation, and 51.02% of practitioners stated that their social or family life and relationships have deteriorated since working in addiction services. The impact of employment in addiction services can be seen in the following comments:

- *They (other people) don't understand the work I do, so conversations can get a bit awkward because of their judgements around addicts.*
- *It can be quite isolating. Many people have strong views about addicts and it can get peoples heckles up.*
- *I am more careful about who I share with, as you quickly realize how small a town can be when working in addictions.*

Those practitioners who reflected a decreased sense of belonging socially as a result of their role also noted that they had gained what they consider to be a significant amount of weight (46.7%). Practitioners who noted an increased sense of belonging since working in addiction services did not notice significant weight gain (0.00%).

Addiction practitioners in this sample reflected that their low energy levels after work were a key component to increased social isolation. This finding is also reflected in literature relating to nurses, with emotional exhaustion being considered common among all levels of nurses (Askarian, 2006; Makhado, 2016), and social support being recognized as one of the largest predictors of reductions in burnout and stress (Makhado, 2016). Responding to the increased social isolation of addiction practitioners requires preventative as well as responsive action, with both peer support and self-care planning recommended based on the results of this study (see recommendations).

Dimension 4: Taha Tinana (Physical wellbeing).

Themes reflecting a deterioration in physical health, a less nutritious diet, and the sedentary nature of the role were consistent upon qualitative and quantitative data review. Comments relating to the sedentary nature of the work include:

- *Once I realised the sedentary nature of the work. I was able to adjust my diet to suit.*

- *The role is far more sedentary than my previous work. I think this is a key cause of the weight gain.*

Of those practitioners who believe that their physical health has deteriorated since working in addiction services, the majority (63.6%) reflect that the foods they eat are less nutritious, and nearly three quarters (71.4%) are consuming more caffeine. Over three quarters (76.2%) of practitioners who believe that their physical health has deteriorated have noted that they promote the importance of physical health to clients, but do not prioritise their own physical health.

There were interactions between a shorter length of service and deterioration in physical and mental health. Additional findings were that increased length of service was more reflective of improvements and stabilization in a practitioner's physical, mental, social and spiritual wellbeing.

There is also a correlation between practitioners who perceive that their physical health has deteriorated, and those who have noted a deterioration in their social and family lives (68.2%). Comments which could assist in developing an understanding of the relationship between a deterioration in physical health and social deterioration are included:

- *I started using amphetamine in the weekends only. It gave me energy to get things done, because I was so tired from the working week. I don't think I have developed an addiction, I just feel it helps me get the most out of my week.*

- *I regularly feel tired/depleted of energy.*

- *I have less sleep, I feel worried about the job. I have less energy.*

- *I developed an eating disorder, anorexia.*

68.2% of practitioners who perceive a deterioration in their physical health also reflect that they spend less time with loved ones since working in addiction services. 57.9% also disagree or strongly disagree that they have become more comfortable expressing their thoughts and feelings.

Summary of key points of addiction practitioner impact based on findings from this research.

This section provides a summary of key points relating to the wellbeing of addiction practitioners based on the length of service and corresponding data provided by the sample. The aim of this section is to identify potential health issues that could be experienced by practitioners and use this summary of key points to inform recommendations which could contribute to the prevention of the onset of these issues. The findings from this study support the findings of practitioner wellbeing impact stated in the literature review (Koinis et al., 2015; Bakker, 2000; Fagin, 1995), and therefore strongly support further examination of the wellbeing of the addiction workforce.

Summary of key points from the sample: First year of practice.

During their first year of practice, practitioners from this sample were most likely to experience significant changes in their personal values and spiritual beliefs (62.5%). Changes in personal values and spiritual beliefs related to becoming a more accepting person (57.14%) and believing that people are 'basically good' (57.14%).

Over half of first year practitioners in this sample felt that they became a more positive person overall, with an improved sense of their own identity (57.14%). Over half of first year practitioners were feeling inspired and fulfilled by life, with 71.43% feeling that their life makes sense most of the time. Nearly all first-year practitioners (87.5%) were able to prioritise their spiritual wellbeing.

First year practitioners experienced equal changes in their family life and relationships, as they did in their personal values and spiritual beliefs (62.5%). Over one half of first year practitioners ended a significant relationship or marriage. A quarter of first year practitioners did not have the energy after work to prioritise relationships with others.

Over one third of first year practitioners experienced a change in their mental health. 37.5% of those practitioners who experienced a change in their mental health experienced an improvement, related to increased feelings of confidence and fulfilment in life, as well as an increased prioritisation of their own wellbeing (57.14%). Equal amounts of first year practitioners experienced a deterioration in their mental health. Deterioration within this sample was influenced by difficulties managing stress, nervousness and emotional problems (66.67%).

Less first year practitioners experienced changes in their physical health (25%) than they did in their mental, social and spiritual wellbeing. Those who did notice changes in their physical health were likely to notice weight loss, (42.86%) weight gain (14.29%), and increased caffeine intake (50%). Most first year practitioners in this sample prioritised their physical health (57.14), with nearly a third noticing that the role helped them sustain their own recovery from addiction.

Summary of key points from the sample: Second and third years of practice.

The wellbeing of this sample of second and third year practitioners was most likely to be impacted in terms of physical and social wellbeing.

87.5% of practitioners who practiced beyond their first year noticed that the foods they ate were less nutritious, with 66.6% expounding the importance of physical wellbeing to their clients, but not prioritising it themselves in their second and third years of practice.

This group of practitioners was less likely to exercise to manage stress, and more likely to consume more alcohol (44.4%) and to take prescription medication (33.33%) to manage stress. Only 11% continued to find that their role helped them sustain their own recovery from addiction, compared to 28.57% of first year practitioners.

Socially, second and third year practitioners in this sample were likely to experience a deterioration in their relationships and family lives (66.67%). Factors contributing to this deterioration included less time spent with loved ones (33.33%), as well as a decreased sense of belonging socially and lacking the energy required to prioritize relationships with others (55.56%).

This decreased sense of belonging socially occurred at double the rate of first year practitioners during the second and third years of practice.

Practitioners in this sample also experienced lower rates of positivity overall compared to their first year of practice during this time (44.44% in the second and third years compared to 57.14% in the first year). There was also a 12.7% decrease in the belief that people are basically good in the second and third years of practice, with the same decrease in practitioners who consider themselves a more accepting person in the second and third years of practice. There was a significant reduction in the number of practitioners who considered that their life makes sense in the second and third years of practice (from 71.43% in the first year of practice, to 33.3% in the second and third years; a 44.13% reduction). These practitioners mostly identified as female (77%) with male practitioners contributing 23% of the sample and non-binary practitioners contributing to 0% of the sample.

Summary of key points from the sample: Fourth and fifth years of practice.

Practitioners at this stage of their practice were most likely to be impacted in terms of their mental health in this sample. Rates of mental health deterioration were higher at this point of practice than at any other stage, with 83.3% of practitioners reflecting a deterioration between their fourth and fifth years of practice. This deterioration was likely to be related to concurrent deterioration reflected in physical, social and spiritual wellbeing. Practitioners in their fourth and fifth years of practice were 39% more likely to develop a substance use issue while working in addiction services than those in their second and third years of practice. 50% noticed an increase in their caffeine use, with an increase of 22.23% in the use of alcohol to manage stress related to the role.

Of interest at this stage of practice was a 22.23% increase in practitioner confidence in expressing thoughts and feelings, alongside a 16.6% decrease in practitioners who feel that their life makes sense and a 15.5% decrease in practitioners who believe that people are basically good.

Other decreases included practitioner sense of personal identity, ability to prioritise spiritual wellbeing, and overall positivity. This stage of professional practice was reflected by the sample to be the most turbulent for practitioners across all dimensions of Te Whare Tapa Wha. 66% of pracititoners within the sample at this stage of practice were male, with females comprising 33% of the sample and 0% identifying as non-binary.

Summary of key points from the sample: Fifth and tenth years of practice.

Practitioners who were previously using alcohol to manage their role related stress within this sample reduced their use of alcohol at this stage of practice, as well as reducing their use of illicit substances. They also increased their use of prescription medication and increased their own prioritisation of their physical health.

Practitioners saw their GP more regularly at this stage of practice, as well as feeling an increased level of care from those who mattered to them. Compared to those in their fourth and fifth years of practice, practitioners at this stage experienced better wellbeing in all dimensions of Te Whare Tapa Wha. This increased sense of wellbeing correlated with an increase in time spent with loved ones, an increase in

the initiation of significant relationships or marriages, and a reduction in incidences of anxiety and panic.

Interestingly, alongside increased perception of mental health improvement, there was also an increase in diagnosis of mental health conditions for practitioners at this stage of practice.

Practitioners in this sample also experienced an improvement in the relationship between their roles and an increased sense of meaning in life, and an increased sense of relevance and purpose long term. Practitioners were more likely to feel inspired and fulfilled by life than those without 5 years' experience, with a 16.67% increase in practitioners who strongly agree that people are basically good and feel more positive overall. Practitioners also experienced a 25% increase in their ability to prioritise their spiritual wellbeing at this stage of practice. Females outnumbered males once again at this stage of practice, making up 81.82% of the practitioner workforce.

Summary of key points from the sample: Tenth and fifteenth years of practice.

Practitioners who continued practicing for over a decade significantly reduced behaviours which may have previously contributed to deterioration in their wellbeing. Based on sample findings, 0% of practitioners at this stage of practice were using illicit substances or using more alcohol than they did before becoming addiction practitioners. 0% of practitioners were smoking, with half of practitioners using prescription medication, and a 41% increase in regular GP attendance from practitioners between their 5th and 10th year of practice. Three quarters of registered practitioners at this stage of practice were male.

Summary of key points from the sample: Practicing for over 15 years.

These experienced practitioners reflected a strong belief that their role give them a sense of meaning in life (100%) and were 100% male. 50% of practitioners who practiced for over 15 years self-identified as New Zealand European. Interestingly, alongside the high rates of meaning in life with these practitioners, 100% also experienced persistent stress or excessive anxiety in their daily life, and 100% consumed more caffeine. The relationship between a high sense of meaning in life, and high rates of stress and anxiety, requires further exploration.

Summary

Although this summary of key points is reflective only of the perceptions of the sample participants, it does raise questions regarding the application of this research to the entire population of addiction practitioners in New Zealand. This summary allows consideration to be given to the interventions and recommendations that could be provided to ensure practice is sustainable for addiction practitioners in New Zealand.

The next chapter will provide an overview of the implications and limitations of this study. The recommendations will also be discussed.

Chapter Seven
Implications, recommendations and limitations.

This chapter will identify the implications, recommendations and limitations related to this study.

Implications

This study has applied the Te Whare Tapa Whā model of health as a framework for measuring the individual wellbeing of addiction practitioners who are employed in New Zealand. This provides an opportunity for the promotion of New Zealand measures of health to be acknowledged as theoretical frameworks, and the further use of Te Whare Tapa Whā in longitudinal wellbeing studies has presented as an opportunity.

This study contributes to a gap in research and wider knowledge about the wellbeing of addiction practitioners in New Zealand. Throughout the literature review process, it became evident that the wellbeing of the healthcare provider was often overlooked when considering how to improve the quality of client care. This research introduces the importance of addiction practitioner wellbeing, especially considering the increasing rates of people requiring support to manage their addictions in New Zealand (MOH, 2016).

The opportunity for practitioners to confidentially assess their own wellbeing offers a unique perspective, as practitioners may be reluctant to share their habits as openly as they have in this research if they were to be identified (for example, by speaking with their GP). The findings of this study present an opportunity for services employing addiction practitioners to better understand and support this workforce through the application of recommendations that will follow these implications.

The opportunity for addiction practitioners to have an increased understanding of the ways the role might impact them is of importance. Practitioners, armed with this knowledge, may choose to plan and prepare ways to ensure their practice is sustainable.

Recommendations

This study aims to measure the impact of employment in addiction services on a practitioner's mental, physical, social and spiritual wellbeing, from the understandings of practitioners. Common approaches to responding to healthcare workforce issues have been largely reactive, such as the offer of employee assistance programmes and supervision following a stressful incident. The following recommendations are supported by the results that have been provided by addiction practitioners participating in this study. Recommendations are included for both individual and organizational application.

Further research

The findings of this study reflected the opportunity for further addiction practitioner specific research. Assessing the impact of peer support on the ongoing wellness of addiction practitioners would be of value. The importance of peer support was reflected in literature which outlined the potential reluctance that healthcare professionals may have in disclosing their challenges to those who they are managed by, and those who are associated with their own professional body.

The establishment of an addiction practitioner's wellness monitoring tool could assist in supporting practitioners with individualised responses to their wellbeing needs throughout their practice. The usefulness of such a tool could be assessed with further investigation. Further exploration of the impact of employment in addiction services on those who are attempting to sustain their own recovery from addiction would also be useful.

Assessing the effectiveness of in service training on the wellbeing of addiction practitioners, as well as assessing the effectiveness of clinical supervision on the wellbeing of addiction practitioners could assist in developing the most effective support opportunities for practitioners.

It is important to consider that the sample were asked to respond based on their self - perception, and additional research would be required to validate these findings with a larger sample of New Zealand based addiction practitioners.

Addiction Practitioner education and development opportunities

It is recommended that trainee addiction practitioners are made aware of the potential impacts of employment as an addiction practitioner on their personal wellbeing. This may take the form of training programmes or specific course modules within the degree or diploma program which explore the issues of effects of practice on practitioner wellbeing, and possible strategies for building awareness and management, such as possible self-care planning and strategies.

There is a strong rationale, based on these findings, that trainee addiction practitioners are explicitly required to show repeated evidence of competencies including self-stress management throughout training, self- recognition of thinking patterns, and reflective practices. There are opportunities for trainee addiction practitioners to display repeated evidence of self-care throughout practicum experiences, supervisor reports and professional conversations throughout their degree or diploma program.

Education and induction programmes for newly employed addiction practitioners present an opportunity for practitioners to accrue continuing professional development points. Continuing professional development (CPD) points are required for the ongoing registration of practitioners in New Zealand. Addiction practitioners in New Zealand must undertake continuing professional development (CPD) activities worth 100 points annually (DAPAANZ, 2018). CPD points can be gained in a variety of ways, including formal study and learning based on work activity. linking CPD points to educational opportunities relating to practitioner wellbeing would support these opportunities to be prioritised organizationally as well as individually.

Peer Support initiatives

Some studies reflect that professional peers are the most commonly elicited sources of support for general medical practitioners and nurses (Brooks, 2013; D'Eon, 2014 & Hu, 2012). In New Zealand, there are no consistent programs of peer support for addiction practitioners that are promoted by registering bodies or advocacy agencies. Despite the trends toward increased requirements for addiction practitioners in terms of valid qualifications, ongoing training and code of ethics compliance (DAPAANZ, 2018), the design of support strategies has not progressed beyond EAP and general supervision, and ongoing support has not increased for

addiction practitioners.

The development of peer support initiatives for addiction practitioners would support those who may not wish to disclose their own coping mechanisms or behaviours to clinical supervisors, for fear of stunting their career progression, loss of professional registration, or experiencing scrutiny from their professional body (Gunter, 2016). The risks of disclosure to clinical supervisors provide a further rationale for peer support programs for practitioners that are not specifically linked to their registering body or professional registration. It is suggested that addressing the mental health of addiction practitioners requires responses which are preventative (peer support, self-care planning at a pre-employment level such as during study) rather than reactive (EAP, clinical supervision) in nature.

Limitations

In this section, the limitations which became evident throughout the research process will be acknowledged and outlined.

This research represents one researcher's application of Te Whare Tapa Whā to this sample and to the research question. This research does not set out to define, critique or use Te Whare Tapa Whā as a general measure for gauging addiction practitioner wellbeing. As this research represents a snapshot in time of a small sample of 53 participants, the findings cannot be deemed representative. The sample size for this study does not allow for broad generalizations to be taken from findings. The small sample size relates to a low response rate, contributing to a high non-response bias.

Although practitioners are invited to provide feedback about the impact of their work relating to the dimensions of Te Whare Tapa Wha, the possible effects of wider social, political and environmental factors on a practitioner's wellbeing are not directly measured within the parameters of this study. This research aims to offer a 'snapshot in time' of the wellbeing of addiction practitioners, as government policy changes could impact the wellbeing of addiction practitioners at a different point in time.

The gap in prior research studies on the topic can also be deemed a limitation, as there is little comparative opportunity between the findings of this study, and other

directly; relevant studies.

This chapter has explored the implications, recommendations and limitations related to this study.

Chapter Eight
Conclusion

This research has explored changes in the wellbeing of a small sample of addiction practitioners since beginning their professional practice, in relation to the dimensions of wellbeing which are represented in the Te Whare Tapa Whā model of health (Durie, 1984). Te Whare Tapa Whā was the theoretical framework which underpinned how health and wellbeing were discussed and explored throughout this research. Te Whare Tapa Whā was also applied to the questionnaire development, data analysis and the framing of discussion and analysis.

Working as an addiction practitioner in an inpatient or community context is a challenging role. The addiction practitioners in this research have identified changes in their physical, mental, emotional and spiritual wellbeing, since becoming a practitioner. While most of the addiction practitioners in this study have identified changes in mental and physical health which may indicate deterioration since working in the field, some practitioners also reflected on the sense of meaning and life satisfaction they have gleaned from their work.

Overall, the findings of this research show a practitioner workforce with notable commitment to the wellbeing of tangata whaiora. Despite this commitment, there are several areas of concern when considering the individual wellbeing of the addiction workforce, which have been outlined in the findings and discussion.

Improving addiction practitioner wellbeing is an addressable issue, with opportunities for improvement outlined in the recommendations of this study. Registering bodies, advocacy agencies, the colleagues of addiction practitioners, and the practitioners themselves have an ethical responsibility to support each other in relation to improving practitioner wellbeing. Each invested party has a critical role to play in improving addiction practitioner wellbeing. New Zealand addiction practitioners and those who train, monitor and support them, are capable of building on the findings of this research to aim to improve the health and wellbeing of the workforce.

The significance of this study can be reflected in the recommendations that have been identified to support this workforce. This research also marks the first time that addiction practitioner wellbeing in New Zealand has been considered by application

of Te Whare Tapa Whā specific to New Zealand. This study addresses a gap in addiction practitioner specific literature in New Zealand and internationally. Although there is some addiction workforce specific research, this body of research has focussed solely on the concepts of stress and professional burnout. No other literature explores the wellbeing of addiction practitioners through a multi-dimensional lens, specifically Te Whare Tapa Wha.

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Appendix 2: Researcher response to Post Graduate Board of Studies

MEMORANDUM

TO: Dr Elizabeth Ashbury
FROM: Lisa Jordan Phillips
DATE: 26 October 2017

SUBJECT: Research Proposal RP27-2017 (Master of Professional Practice)

I have considered the feedback of the Board from the meeting held on 05 October 2017 and made the required amendments, for submission to the Chair of Postgraduate Board of Studies, Dr Elizabeth Asbury for final approval.

Research Title: 'How the wellbeing of addiction practitioners is affected by their professional practice'.

Suggested amendments:

It is at the discretion and agreement with the supervisor whether to include the quantitative questions.

I have consulted with my research supervisor, and would like to include the quantitative questions. I am aware of the limitations regarding the small scale of the research, however I believe these questions will add further context to other responses throughout the questionnaire. I believe the inclusion of these questions will balance any response/or lack of response from the other question forms, and allow opportunity for triangulation with other forms of response.

The Questionnaire: amend the references to "my relationship with God or a higher power" to "my religion".

Feedback accepted, with required amendment evidenced in attached updated questionnaire.

The Board queried what guidance was sought regarding Māori philosophy and concepts. The Student and supervisor to contact the Acting Dean, Te Wānanga Māori for guidance.

Guidance has been sought over an extended timeframe. I have been supervised professionally by cultural supervisor Maynard Gilgen for over three years. On recommendation from PGBoS, I have also sought advice from Jeanette Grace, Acting Dean, Te Wananga Maori for guidance. Jeanette Grace was supportive of my choice to work with Maynard Gilgen. Feedback from Maynard Gilgen, as well as feedback provided by Jeanette Grace, is provided below. Interpretation and application of Te Whare Tapa Whā has been consultative and will continue to be. Key concepts from consultation have been as follows:

Cultural supervisor Maynard Gilgen's main priority is that the research honours the mana, tapu and mauri of the people we work with – and flowing on from this, the principles of tika, pono and aroha are carefully observed. He advocated strongly for familiarity with the whakapapa of the Te Whare Tapa Whā model, and learning how

the model hails from World Health Organization origins. Maynard wanted me to be clear on the shortcomings of the model, and to have a response for why I relate so strongly to Te Whare as a preferred health model for my research. Also recommended was that I become fluent in sharing my story towards the model – and responding to why I choose Te Whare Tapa Whā to Manaaki our staff in their professional practice. Application of the model has been supported by literature (Glover, 2005; Durie, 1985), especially in relation to the choice of this model for measuring the health of New Zealanders specifically. It is noted through consultation and literature that Te Whare Tapa Whā provides a clear framework against which to assess the comprehensiveness or 'holism' of the wellbeing of addiction practitioners. The questionnaire structure and format specifically relates to these dimensions of wellbeing (Glover, 2013).

Jeanette Grace framed the following questions:
-When I look at my questionnaire questions do they speak from the Imperial landscape only?
-Is there ability for someone who experiences wellness differently to have a voice?

My response was that Taha Wairua and whakapapa are evident throughout the questions. This will be elaborated further in the writing of the thesis (literature review, methodology, discussion sections). Some examples are included below:
-I have a strong sense of my own identity (whakapapa)
-My life makes sense most of the time (Taha Wairua)
-Open form: Any other comments you would like to add regarding how your personal values and spirituality has been affected by working in addiction services?
-Since I have been working in addiction services (Please check all that apply) I feel I am more cared about by people who matter to me (Whanau)

There are multiple opportunities for someone who experiences wellness differently to comment with their views in an open comment format. Jeanette responded that the main thing is that I am cognisant of the dissonance between western and Maori constructs. The questionnaire itself is framed structurally in relation to Te Whare Tapa Wha.

Consultation will continue 4-weekly throughout the research process, alongside cultural supervisor Maynard Gilgen, and Dr Stephanie Kelly. Maynard can be contacted here: maynardgilgen@gmail.com.

Kind regards,
Lisa Phillips.

Appendix 3: Post Graduate Board of Studies Approval to Proceed

31 October 2017

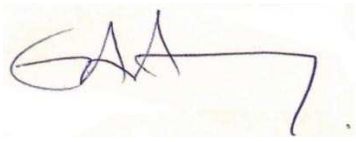
Lisa Jordan Phillips
C/o School of Social
Services WelTec

Dear Lisa
The Postgraduate Board of Studies met on 05 October 2017 to consider your application to proceed with your Research Proposal entitled 'How the wellbeing of addiction practitioners is affected by their professional practice'.

The Board has approved the research project No: RP27-2017 for your Master of Professional Practice qualification. This research proposal has been assessed as of low ethical risk and you can now proceed as planned with your research project.

Please insert this letter as an appendix into your praxis/report. The Board wishes you success with your research project.

Yours sincerely



Dr Elizabeth Asbury
Chair, Postgraduate Board of Studies

Appendix 4: Information sheet

How the wellbeing of addiction practitioners is affected by their professional practice.

Thank you for your interest in this research project. This information is provided so that you can make an informed decision about participating in this study.

This project is being undertaken by Lisa Phillips and has been approved by the Ethics and Research Committee.

What is the purpose of the project?

The purpose of this research is to better understand the ways that addiction practitioners are affected by their work. This research will be informed by the Te Whare Tapa Whā model of health.

What type of participant are we looking for?

We are looking for registered AOD practitioners, who are listed on the DAPAANZ registered practitioner database.

What are the possible benefits and risks of participation?

The potential benefits of this study include improved support for addiction practitioners, as well as an increased awareness for trainees in relation to the potential effects of the role on their lives. Potential risks include the discomfort that some of the more difficult questions will raise. Details of support agencies will be made available to participants.

What will participants be asked to do?

Participants will be asked to complete a confidential online questionnaire, which should take a maximum of 20 minutes to complete.

Can participants change their mind and withdraw from the project?

You can withdraw from the project at any time. No reason is needed if you choose to withdraw. There will be no disadvantages to you of any kind, or any consequences.

What information will be collected and what use will be made of it?

Data will be collected using the Survey Monkey online tool. It will be analysed thematically and statistically.

Will the information remain confidential and anonymous, and how will this be done?

All information will be kept strictly confidential, and no names will be used. When the results are published you will not be personally identified. Any information collated once the research is complete can be viewed at any time.

Is there a cost of taking part?

It will not cost you anything to take part in this study.

What if I want more information?

If you have any questions about this project, at any time, you can contact the research supervisors:

Dr. Stephanie Kelly: Primary supervisor:
Stephanie.Kelly@weltec.ac.nz Cynthia Young:
Secondary supervisor:
Cynthia.young@weltec.ac.nz

Appendix 5: Informed Consent

INFORMED CONSENT

Your participation in this study is entirely voluntary. If you choose to take part, you are free to withdraw from the project at any time, and can withdraw the information provided, without any consequence, before you click 'Submit'.
Please check the box to confirm you are aware that once this questionnaire has been submitted, you will be unable to withdraw the information you have provided □
Please check the box to confirm that you have read the Information Sheet about this research project, and understand what it is about □

I agree to take part in the study □

Appendix 6: Questionnaire

QUESTIONNAIRE

Demographic questions (Open form comment)

Months/years of service as a

practitioner Ethnicity

Gender identity

General question:

Since working in addiction services, I have noticed (Check all that apply)

-a change in my physical health

-a change in my mental health

-a change in my personal values or spiritual beliefs

-a change in my social or family life and relationships

Taha tinana - Questions on physical health

Since working in addiction services, I have noticed

- My physical health has improved
- My physical health has deteriorated
- My physical health has remained the same
- Comments:

Since working in addiction services

- I have gained what I consider to be a significant amount of weight
- I have lost what I consider to be a significant amount of weight
- My weight has remained the same
- My weight has fluctuated
- Comments:

Since working in addiction services

- The foods I eat are more nutritious
- The foods I eat are less nutritious
- The foods I eat are the same as usual
- The pattern fluctuates
- Comments:

When you feel stressed by your job, do you engage in any of the following? (Check all that apply).

- consuming more caffeine
- smoking
- exercising more frequently
- taking over-the-counter medication
- Taking prescription medication
- consuming more alcoholic beverages
- taking illicit substances
- sleeping more
- eating more
- talking to family or friends
- talking to a medical or mental health professional

Please check all that apply

- I promote the importance of physical health to clients, and I prioritise my physical health.
- I promote the importance of physical health to clients, but I do not prioritise my physical health.
- Working in addiction services helps me sustain my own recovery from addiction
- Working in addiction services makes it difficult for me to sustain my recovery
- I have never had a substance use issue
- I developed a substance use issue while working in addiction services
- I see my GP more regularly since working in addiction services
- I see my GP less regularly since working in addiction services
- Open form: Any other comments you would like to add regarding how your physical health has been affected by working in addiction services?

Taha whānau - Questions on whanau and relationships

Since working in addiction services, I have noticed

-My social or family life and relationships have improved

-My social or family life and relationships have deteriorated

-My social or family life and relationships have remained the same

-Comments:

Since working in addiction services

-I spend more time with loved ones

-I spend less time with loved ones

-I spend the same amount of time with loved ones

Comments:

Since working in addiction services

-I have started a significant romantic relationship or marriage

-I have ended a significant romantic relationship or marriage

-My relationship status has remained the same

Comments:

Since I have been working in addiction services (Please check all that apply)

-I have enough energy after work to prioritize relationships with others

-I don't have enough energy after work to prioritize relationships with others

-I have the same amount of energy after work to prioritize relationships with others

-I feel an increased sense of belonging socially

-I feel a decreased sense of belonging socially

-I have the same sense of belonging socially

Since I have been working in addiction services (Please check all that apply)

-I feel I am more cared about by people who matter to me

-I feel I am less cared about by people who matter to me

-I feel the same level of care from the people who matter to me

-I have more people with whom I can share what I am really feeling and thinking

-I have less people with whom I can share what I am really thinking and feeling

-I have the same amount of people with whom I can share what I am really thinking and feeling

Open form: Any other comments you would like to add regarding how your social life and family relationships have been affected by working in addiction services?

Taha hinengaro - Questions on mental health

Since working in addiction services, I have noticed

- My mental health has improved
- My mental health has deteriorated
- My mental health has remained the same
- My mental health has fluctuated
- Comments:

Evaluate the following statements:

(Strongly Disagree, Disagree, Agree, Strongly Agree) Since working in addiction services:

-I have become more comfortable expressing my thoughts and feelings

-I been bothered by feeling down, depressed or hopeless

-I feel confident in who I am, and what I have to say

-I feel bothered by little interest or pleasure in doing things

Comments

Since I started working in an addiction service, I… (Check all that apply)

-experience persistent stress or excessive anxiety in my daily life.

-have taken prescription medication to manage stress, nervousness, emotional problems or lack of sleep.

-have had an anxiety or panic attack.

-have been diagnosed with a mental health condition

Comments

Taha wairua - Questions on spiritual health Please check all that apply

I believe that the work I do

-Gives me a sense of meaning in life

-Has no relevance or purpose long term

-Has strengthened my relationship with God or a higher power

-Has weakened my relationship with God or a higher power

Comments

Evaluate the following statements:

Since working in addiction services:

-Im feeling inspired and fulfilled by life

(Strongly Disagree, Disagree, Agree, Strongly Agree)

-My life makes sense most of the time

(Strongly Disagree, Disagree, Agree, Strongly Agree)

-I have become a more accepting person

(Strongly Disagree, Disagree, Agree, Strongly Agree)

-I believe people are basically good

(Strongly Disagree, Disagree, Agree, Strongly Agree)

-I am a more positive person overall

(Strongly Disagree, Disagree, Agree, Strongly Agree)

-I have an improved sense of my own identity

(Strongly Disagree, Disagree, Agree, Strongly Agree)

Comments

Since working in addiction services, I have been able to prioritise my spiritual wellbeing.

Yes

No

Other (explain)

Comments

Open form: Any other comments you would like to add regarding how your personal values and spirituality has been affected by working in addiction services?

Open form: Any other comments you would like to add regarding your health, wellbeing, and your professional practice?

Would you like to receive a copy of the findings of this questionnaire once these are available? If so, please enter your email address here. (Please note: Your email address will remain separate from the information you have entered so far).

Closing comments.

Appendix Seven

Message service on DAPAANZ website

Lisa Jordan Phillips

Send a Message

Other Details

Status:	Registered AOD/PG Practitioner
Primary Region:	Wellington

Appendix Eight

Excel spreadsheet for data analysis

How the wellbeing of addiction practitioners is affected by their professional practice.	
Q1. Please indicate your understanding of the following informed consent considerations.	
Answer Choices	Responses
I understand that once this questionnaire has been submitted, I will be unable to withdraw the information I have provided.	100.00%
I have read the Information Sheet about this research project, and understand what it is about.	100.00%
I agree to take part in the study.	100.00%
Q2. Since working in addiction services, I have noticed (Check all that apply)	
Answer Choices	Responses
a change in my physical health	54.00%
a change in my mental health	66.00%
a change in my personal values or spiritual beliefs	56.00%
a change in my social or family life and relationships	46.00%
Q3. Since working in addition services, I have noticed (Check all that apply)	
Answer Choices	Responses
my physical health has improved	28.00%
my physical health has deteriorated	44.00%

my physical health has remained the same	28.00%

Comments
I work out, nothing to do with job. Still same physically. I have gained weight. I feel like a liar if I don't keep fit, but always tell my clients to keep fit. Due to unhealthy initial toxic work situation, my health deteriorated markedly. Since the work situation has changed my health has improved, but a lot of damage was done that has repercussions for the rest of my life. I have less sleep, I feel worried about the job. I have less energy. I am careful about what I eat now. I exercise every weekday now. I think because I need it to clear my head before work, it helps me feel in control of my day. Regularly feel tired/depleted of energy.

Q4. Since working in addiction services (Check all that apply)	
Answer Choices	Responses
I have gained what I consider to be a significant amount of weight	32.00%
I have lost what I consider to be a significant amount of weight	34.00%
my weight has remained the same	26.00%
my weight has fluctuated	20.00%

Comments
Once I realised the sedentary nature of the work. I was able to adjust my diet to suit. Due to eating more nutritious food. The role is far more sedentary than my previous work. I think this is a key cause of the weight gain.

Q5. Since working in addiction services (Check all that apply)	
Answer Choices	Responses
the foods I eat are more nutritious	18.75%
the foods I eat are less nutritious	54.17%
the foods I eat are the same as usual	16.67%
the pattern fluctuates	16.67%
Comments	
I developed an eating disorder, anorexia. This has nothing to do with my job, I have simply become more health conscious as I mature. No time as I start early and finish late. Much more aware of the nutritious quality of my food and drinks. Food provided within services were allocated to us also and these were terrible foods. So many meetings, so much cake.	

Q6. When you feel stressed by your job, do you engage in any of the following? Check all that apply.	
Answer Choices	Responses
consuming more caffeine	54.17%
consuming less caffeine	2.08%
smoking	25.00%
exercising more frequently	31.25%
exercising less frequently	25.00%

taking over-the-counter medication	14.58%
taking prescription medication	29.17%
consuming more alcoholic beverages	37.50%
consuming less alcoholic beverages	0.00%
taking illicit substances	25.00%
sleeping more	22.92%
sleeping less	18.75%
eating more	31.25%
eating less	14.58%
talking to family or friends	16.67%
talking to a medical or mental health professional	16.67%

Q7. Please check all that apply	
Answer Choices	Responses
I promote the importance of physical health to clients, and I prioritise my physical health	29.17%
I promote the importance of physical health to clients, but I do not prioritise my physical health	52.08%
Working in addiction services helps me sustain my own recovery from addiction	27.08%
Working in addiction services makes it difficult for me to sustain my recovery	12.50%

I have never had a substance use issue	8.33%
I developed a substance use issue while working in addiction services	8.33%
I see my GP more regularly since working in addiction services	29.17%
I see my GP less regularly since working in addiction services	8.33%
Any other comments you would like to add regarding how your physical health has been affected by working in addiction services?	4.17%

Comments
I take care of myself much more as I have learned from what I teach. I started using amphetamine in the weekends only. It gave me energy to get things done, because I was so tired from the working week. I don't think I have developed an addiction, I just feel it helps me get the most out of my week.

Q8. Since working in addiction services, I have noticed (Check all that apply)	
Answer Choices	Responses
my social or family life and relationships have improved	12.24%
my social or family life and relationships have deteriorated	51.02%
my social or family life and relationships have remained the same	32.65%

Comments
Just changed- neither better nor worse. Stagnated. They don't understand the work I do, so conversations can get a bit awkward because of their judgements around addicts. As I am continually teaching and talking about communication skills with my clients, I have noticed that I am increasingly aware of the way I communicate.

This has made me far more conscious of the words I say, and why I react the way I do. Thoughts leading to feelings and actions has influenced the way I choose to respond.

Q9. Since working in addiction services (check all that apply)	
Answer Choices	Responses
I spend more time with loved ones	27.45%
I spend less time with loved ones	43.14%
I spend the same amount of time with loved ones	27.45%
Comments	
No comment no impact re job just life I spend a lot of time at work now. Working with people who have often lost a large connection with their families and loved ones, reinforces for me, the importance of prioritising these relationships.	

Q10. Since working in addiction services (Check all that apply)	
Answer Choices	Responses
I have started a significant romantic relationship or marriage	22.45%
I have ended a significant romantic relationship or marriage	51.02%
my relationship status has remained the same	28.57%
Comments	
Yeah but an arsehole Amway. Probably would've left sooner if I was still a black & white thinker. I'm not in a romantic relationship.	

Q11. Since I have been working in addiction services (Check all that apply)	
Answer Choices	Responses
I have enough energy after work to prioritize relationships with others	16.33%
I don't have enough energy after work to prioritize relationships with others	51.02%
I have the same amount of energy after work to prioritize relationships with others	12.24%
I feel an increased sense of belonging socially	4.08%
I feel a decreased sense of belonging socially	32.65%
I have the same sense of belonging socially	22.45%
Q12. Since I have been working in addiction services (check all that apply)	
Answer Choices	Responses
I feel I am more cared about by people who matter to me	17.02%
I feel I am less cared about by people who matter to me	25.53%
I feel the same level of care from people who matter to me	27.66%
I have more people with whom I can share what I am really feeling and	14.89%

thinking	
I have less people with whom I can share what I am really feeling and thinking	44.68%
I have the same amount of people with whom I can share what I am really thinking and feeling	8.51%
Comments	
I am more careful about who I share with, as you quickly realize how small a town can be when working in addictions. I don't want to share too much of what is happening at work. I fear I may pass on some confidential detail about a client accidentally, I also fear that people may find the work I do a bit morbid so I tend not to talk about it. It can be quite isolating. Many people have strong views about addicts and it can get peoples heckles up.	
Q13. Since working in addiction services, I have noticed	
Answer Choices	Responses
my mental health has improved	14.58%
my mental health has deteriorated	45.83%
my mental health has remained the same	12.50%
my mental health has fluctuated	27.08%
Comments	
I developed depression which I require antidepressants for. I developed insomnia. Due to non-clinical management.	

Depression.
Always stressed about my clients and I feel too responsible for them.
I have learnt HEAPS about keeping myself mentally healthy.
Doubting my self-worth and competence in the job.

Q14. Since working in addiction services

	Strongly disagree	Disagree	Agree	Strongly agree
I have become more comfortable expressing my thoughts and feelings	12.77%	31.91%	38.30%	17.02%
I have been bothered by feeling down, depressed or hopeless	14.58%	27.08%	31.25%	27.08%
I feel confident in who I am, and what I have to say	21.28%	19.15%	44.68%	14.89%
I feel bothered by little interest or pleasure in doing things	19.15%	29.79%	38.30%	12.77%

Q15. Since working in addiction services I…(check all that apply).

Answer Choices	Responses
experience persistent stress or excessive anxiety in my daily life	48.84%
have taken prescription medication to manage stress, nervousness and emotional problems or lack of sleep	48.84%
have had an anxiety or panic attack	25.58%
have been diagnosed with a mental health condition	16.28%

Comments

None of the above. Due to the high level of responsibility I feel for my clients. I feel like if they lapse, it's my fault. If anything at all goes wrong for them, I question what I could have done differently to stop it from happening. It's exhausting. Sleeping tablets - i have seen my GP to get these when work stress has been severe.

Q16. I believe that the work I do (Check all that apply)	
Answer Choices	Responses
gives me a sense of meaning in life	53.06%
has no relevance or purpose long term	10.20%
has strengthened my relationship with my religion	40.82%
has weakened my relationship with my religion	8.16%
Comments	
Loss of faith in God after seeing how badly people get treated. I hope I am making a difference.	

Q17. Since working in addiction services				
	Strongly disagree	Disagree	Agree	Strongly agree
I am feeling inspired and fulfilled by life	22.22%	28.89%	37.78%	11.11%
my life makes sense most of the time	21.74%	28.26%	43.48%	6.52%

I have become a more accepting person	15.22%	26.09%	47.83%	10.87%
I believe people are basically good	17.78%	28.89%	42.22%	11.11%
I am a more positive person overall	13.04%	34.78%	39.13%	13.04%
I have an improved sense of my own identity	4.35%	43.48%	43.48%	8.70%
Comments				
Not encouraged by employers my own work				

Q18. Since working in addiction services, I have been able to prioritise my spiritual well being	
Answer Choices	Responses
No	49.02%
Yes	49.02%
Other	1.96%
Comments	
I feel a loss in terms of my relationship with God, it's hard to connect with a God who could ease suffering, but doesn't. It's hard to imagine that because of an adult's free will, a child might be neglected or abused. Really hard to understand how god doesn't act or protect the vulnerable when it is within his power to do so. The work challenges your faith.	

Q19. Any other comments you would like to add regarding how your personal values and spirituality have been affected by working in addiction services?

For me the journey to this vocation has always been to reinforce my recovery this includes the spiritual and ongoing education required.

No

Cynical and disillusioned to some degree

no

Step 12 values are more important

I am a person with extreme compassion and empathy. I'm VERY easily manipulated.

No

No

They have become much more real and central to my living life to the fullest.

No

I have learned the value of every little interaction. Everything you say can affect another person, you have to be so careful with people because you never know what could hurt them. I still have a strong faith in God, I just understand him less since working in addiction.

The work I do has meaning to me, and it is rewarding to see people recover. Recovery improves my faith, I struggle with clients who relapse when I think of a God who is good, especially when those clients have children and families. Sometimes I wish God would just 'step in' But I also understand free will. That is the challenge for me, wanting God to act but knowing the client has to do the work.

Q20. Are there any other comments you would like to add regarding your health, wellbeing and your professional practice?

I have always maintained a strict boundary between my work commitments in order to not suffer any mental health issues

No

Became increasingly difficult to stay healthy and enthusiastic

Sometimes I don't know if it is my professional practice that is linked directly to my wellbeing, or other aspects of life.

no

Addiction services screw you over due to politics & idiots. Not valued for your actual work

no

My health and wellbeing are borderline fair.

No No My health wellbeing and professional practice has become strongly aligned. No You really can't separate who you are from the work you do in addictions. If you are angry, the clients will know about it. If you are sad, they try to take care of you. If you don't look after yourself, you can't look after your clients properly. I have noticed that I am far more conscious of my own wellbeing since working in the addiction field. Interesting to be asked about my own well-being when generally we only think about how the clients are doing
Q21. If you would like to receive a copy of the findings of this questionnaire once they are available, please enter your email address here. (Please note: your email address will remain separate from the information you have entered so far).
Answered 4. (These have been removed to protect participant anonymity).

Q22. Please indicate your length of service as an addiction practitioner	
Answer Choices	Responses
1 year or less	19.51%
Over 1 year, up to 3 years	21.95%
Over 3 years, up to 5 years	14.63%
Over 5 years, up to 10 years	29.27%
Over 10 years, up to 15 years	9.76%
Over 15 years	4.88%
Q23. (Optional) Please indicate your gender identity	

Answer Choices	Responses
Male	41.03%
Female	58.97%
Non binary	0.00%
Q24. (Optional) Please provide your ethnicity	
Participants typed their own response.	Responses
Maori	15.38%
Pakeha	7.69%
New Zealander	0.00%
New Zealand European	38.46%
Caucasian	19.23%
Italian	3.85%
Irish	3.85%
White	3.85%
Kiwi	3.85%
New Zealand Pakeha	3.85%