Developing a comprehensive, integrated and contemporary recovery oriented dual diagnosis service, within the environment of primary and continuing care in Cork, Ireland

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Declaration

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of PhD is entirely my own work, and that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

Signed (Candidate): _____ Student No: 12211376.

Date: January 2018

Dedications

This dissertation would not have been completed, without the support, encouragement, guidance and participation of many people, over the course of the inquiry. I would like to express my appreciation to all of them, and for their role in enabling the completion of my dissertation.

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List of Acronyms

AA: Alcoholics Anonymous

AAMHU: Acute Adult Mental Health Unit

ADON: Assistant Director of Nursing

CHO: Community Healthcare Organisation

CNM: Clinical Nurse Manager – levels I, II and III

CUH: Cork University Hospital

DD: Dual Diagnosis

Detox: Detoxification

DOH: Department of Health

DRA: Dual Recovery Anonymous

DSM: Diagnostic and Statistical Manual (Versions I-V)

ED: Emergency Department

EMCDDA: European Monitoring Centre for Drugs and Drug Addiction

GF: Ground Floor (former mental health unit in CUH)

GP: General Practitioner

HSE: Health Service Executive

IMO: Irish Medical Organisation

MDT: Multi-Disciplinary Team

NA: Narcotics Anonymous

NACD: National Advisory Committee on Drugs and Alcohol

OPD: Out-Patient Department

OT: Occupational Therapist

PAR: Participatory Action Research

SCAN: Suicide Crisis Assessment Nurse

WHO: World Health Organisation

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Abstract

Author: John P. Connolly

Title/Aim: Developing a comprehensive, integrated and contemporary recovery oriented dual diagnosis service, within the environment of primary and continuing care in Cork, Ireland.

Background: The mental health services and addiction services, generally function independently of one another. Where an individual experienced mental ill health and addiction simultaneously, access to appropriate services was compromised. In this, no specific service was locally available.

Objectives:

- To engage stakeholders in PAR's methodological framework to facilitate a clear pathway to services
- To engage stakeholders in a critical reflective process of inquiry
- To enact pragmatic developments in service delivery that demonstrates positive outcomes for clients
- To contribute to learning, knowledge development and new ways of knowing

Methodology: Participatory Action Research (PAR) methodologies were adapted to a Health Service Executive (HSE) organisational context, where three research cycles (phases) of inquiry enabled the development of a new dual diagnosis (mental health and addiction) service. Methods employed included, field notes, journaling, individual interviews, participant observation and case studies.

Pragmatism was employed as the most suitable guiding theoretical perspective that underpinned the inquiry process.

Findings:

Cycle One demonstrated that emerging percepts shaped the formation of required service developments, leading to the emergence of a practical theory.

Cycle Two included the implementation of service developments initiated in Cycle One. Findings demonstrated participant perspectives of the evolving service, while stakeholders developed the service's operational policy. The service developments were embedded further, contributing to service sustainability. New percepts emerging, contributed collectively to further refinement of the practical theory.

Cycle Three included practice transformation, where representatives from relevant organisational-hierarchical tiers participated in the implementation of the new dual diagnosis service. Some percepts ended upon implementation, while others modified the practical theory further. Findings from participants' case studies demonstrated application of the theory in practice.

Contribution to knowledge and service development: In this study, PAR has demonstrated efficacy as a transforming agent through new ways of doing – evident in the design, construction and implementation of a dual diagnosis service. Within this inter-relational process, a co-constructed perceptual framework and a new way of knowing has emerged. The three Cycles of this inquiry have exhibited how (a) the social validity criteria of *comprehensibility, truth, rightness and authenticity* were present, and (b) how the research claims made were validated, and can therefore be upheld.

CHAPTER ONE: INTRODUCTION

This chapter outlines the aim and objectives of this Participatory Action Research (PAR) inquiry and explains the impetus for the inquiry, how it emerged and how it led to a decision to develop a new dual diagnosis service in Cork city. This is followed by an overview of the environmental context within which the inquiry took place, and the personal/professional influences of the author within this context. Different treatment systems, approaches and integration are then introduced, which are followed by an introduction to the subsequent dissertation chapters.

Consistent with the form and approach of PAR, I have written the overall dissertation as a co-participant in the inquiry and therefore located in the context. In relation to the inquiry process, Cycles One, Two and Three are written in narrative and chronological format in an accessible style of language. This approach is compatible with PAR (Reason and Bradbury, 2008, p.31) and blends well with my philosophical worldview and ways of knowing, and has further satisfied my ethical beliefs about conducting participatory research. My choice of PAR was based on its flexibility to facilitate the active participation of the organisation's service-users and employees in the co-construction of knowledge, whilst advancing their quality of life.

Aim and Objectives of the inquiry

The overall aim of the inquiry is to develop a comprehensive, integrated and contemporary recovery-oriented model of care for dual diagnosis within the environment of primary and continuing care in Cork, Ireland.

The aim of the inquiry will be met through the following objectives:

- to engage stakeholders in PAR's methodological framework in order to facilitate a clear pathway to services;
- to engage stakeholders in a critical reflective process seeking to collectively understand existing and emerging concepts and beliefs relative to the topic of inquiry (dual diagnosis and related service transformations);

- to enact pragmatic developments in service delivery (through PAR) that demonstrates positive outcomes for clients (stakeholders) and families experiencing dual diagnosis;
- to contribute to learning, knowledge development and new ways of knowing for stakeholders concerned with dual diagnosis.

Background

The impetus for this inquiry emerged from:

(a) the co-location of mental health and primary care addiction services in a community setting, enabling practitioners from both services to discuss the need for a specific dual diagnosis service; service-users were attending disintegrated services with challenges both for individuals and for practitioners' caseloads; service-users attended the mental health service for mental health concerns and the addiction service for their addiction concerns, while their subjective experience of such co-occurring issues necessitated a specific dual diagnosis service.

(b) my personal and professional motivation to lead this methodological approach (PAR), aiming to develop an innovative dual diagnosis service.

MacGabhann et al. (2004, p.43) recommended that those experiencing dual diagnosis should be ideally responded to within an integrated service delivery model, and preferably in a community setting. In keeping with this recommendation, Connolly et al. (2010, p.32) described the co-location and integration of mental health and addiction services in Cork city as providing '*an ideal environment for service development'* in general and the recommended '*integrated model'* in particular.

Drake et al. (1998) developed the integrated model in the USA, consisting of teams working to deliver interventions for addiction and mental health concerns simultaneously. Ley et al. (2000) suggested that greater levels of engagement and lower rates of dropout from treatment were benefits of this model. Since 2000 to date, policy-makers in England, Scotland, Wales and Australia have been adopting this model as a way forward (Connolly et al. 2010; see also Literature Review chapter, pp.62-65).

In relation to this inquiry, it was proposed that a critical understanding of the concepts associated with the integrated model for dual diagnosis be identified. One of the inquiry's

objectives stated that such a comprehensive understanding would authenticate through practice a recovery-oriented assessment and treatment model in the environmental context of primary care (PCC). Connolly et al. (2010) cited possible implications for practice emerging from the implementation of the integrated model for dual diagnosis, which included:

> • *assessment/treatment guidelines and protocols for staff will help to define practice;*
>
> • *the development of an up-skilled and integrated dual diagnosis response team (mental health and addiction professionals) will evolve over time;*
>
> • *client participation in the establishment of services is paramount in order to achieve effective outcomes;*
>
> • *a more evidence-based practice will emerge from current pilot studies;*
>
> • *other healthcare settings can mirror this integrative concept*
>
> Connolly et al. (2010, p.32)

The Irish government's publication, *A Vision for Change* (Department of Health and Children, 2006, p. x), recommended the benefits of service integration and said that '*client participation in service development should be paramount*'. PAR in its methodological and pragmatic approach has facilitated this participation, allowing the emergent data to illustrate how dual diagnosis is directly experienced and responded to by participating stakeholders. Furthermore, the engagement of an action-oriented paradigm in practice helped to establish a closer collaboration between professionals and service-users who actively participated in the process.

> '*Action research is emancipating when it aims not only at technical and practical improvement and the participant's better understanding, along with transformation and change within the existing boundaries and conditions, but also at changing the system itself of those conditions which impede desired improvement in the system/organisation*'.
>
> Zuber-Skerritt (1996, pp.4-5)

Building on this impetus, the *Transformation Programme 2007-2010* (Health Service Executive, 2006) outlined how Ireland's health services ought to be fundamentally reformed and delivered. Recommendations in the document included:

• *the collaboration of the specialised mental health services with primary care addiction services;*

• *engagement by staff in facilitating change and developments as well as attitudes to service provision;*

• *a reconfiguration of staff and resources towards community settings, with co-location being recommended* (p.17).

Ireland's National Drug Strategy (Government of Ireland, 2009, p.42) also supported these policy documents, recommending that the development of specialist expertise and service development in the context of dual diagnosis be delivered in community and primary care settings.

The tenet of participation as a core element of active social research, as in this PAR inquiry, brings with it a pragmatic shift in terms of democratising the research process, in contrast to the traditional dichotomy between the researcher and research participants (Reason and Bradbury, 2001). This participatory approach, being a core principle of PAR, suited this inquiry, in which participation at all levels of service development was facilitated for all stakeholders, especially service-users. Further, and in contrast to positivistic approaches, the incorporation of the reflexive approach allowed researchers to fully engage in the research process and not be eliminated as an influence through their beliefs and values on the impetus for the inquiry nor on the final outcomes:

'*Reflexivity is a developed skill and ability to deepen our awareness to the world around us, and to use that knowing to inform our actions, communications and understandings*'. Etherington (2004, p.19).

The general perception of action research as an iterative process of cycles (Lewin, 1946/1997:146) blended well with the aim of developing a contemporary model for dual diagnosis, as the processes of data collection fed back directly into the practice as it evolved, thus transforming practice Cycle by Cycle (see further, the Methods chapter, pp.113-138 and the Cycle chapters One, Two and Three).

The environmental context/location of the inquiry

While Connolly et al. (2010) describe the local and environmental context before the initiation of the inquiry, an overview here is appropriate. The inquiry focused on the HSE's South Lee

sectoral area of Cork city, where the local primary care addiction service and mental health services were co-located (Connolly et al. 2010). The bulk of the inquiry process occurred in the following locations: Togher Community Centre; within HSE buildings, including Ward GF and the new mental health unit (AAMHU) in Cork University Hospital (CUH); Arbour House Addiction Treatment Centre in St. Finbarr's Hospital; Kinsale Primary Care Centre and a HSE mental health services building on St. Patrick's Road, Cork. These locations are introduced here individually in the context of the inquiry and the evolution of the dual diagnosis service (p.31).

Ward GF closed permanently and the new acute mental health unit opened in August 2015 during Cycle two of the inquiry. The new purpose-built South Lee Mental Health Unit building is adjacent to the main hospital. The process of the dual diagnosis team's engagement with in-patients on the new unit mirrors that followed in the old ward.

Togher Community Centre has evolved as the hub of dual diagnosis services in this community from 2010 to date (Connolly et al. 2010; 2015). After working with a specialist addiction service in Cork, I took up the post of South Lee primary care addiction counsellor in 2007, where my employer, the HSE, pay for my accommodation in the community centre for 1.5 days per week. I also provide addiction services in other locations within South Lee for the remainder of the week. Around that time (2007-2008), the mental health services also began seeing people in this community setting. A clinical nurse manager, mental health social worker, an occupational therapist and a staff nurse are based there. The mental health team holds weekly clinics, business meetings, and clinical team meetings concerned with the management and delivery of many services at the centre. This inquiry's core research group also met at the community centre throughout the inquiry.

The rooms in which the dual diagnosis services are conducted are bright, warm and comfortably furnished. In the planning phase of the inquiry, service-users agreed that this location was best suited to respond to their needs, as they said they could meet their peers and the multi-disciplinary team in a familiar environment in their own community. After discussion with the dual diagnosis team, many who had been seen previously by the mental health services in the main hospital (CUH) requested to be seen in future in the community centre.

Arbour House, run by the HSE, is a specialist out-patient addiction treatment centre located in St. Finbarr's Hospital. Before the inquiry began I had established links with personnel and services at this centre, with its director being my line manager and many staff being previous work colleagues. In the context of delivering addiction services in the South Lee area and my role in the development of the dual diagnosis service, my links with Arbour House were largely administrative. However, as Connolly et al. (2010) illustrate, with authorisation from Arbour House management, persons experiencing dual diagnosis and engaged with our dual diagnosis service agreed to engage with the acupuncture service provided at that treatment centre.

Kinsale Primary Care Centre opened in August 2014 as cycle one was merging into cycle two. Although about 30km from where most of the inquiry/service developments took place, this building also accommodates local mental health services, a primary care addiction service, an adjacent GP practice and many other primary care disciplines. As I frequently received referrals from the Kinsale mental health team and GPs in this area, in the context of dual diagnosis, all local clients were assessed in this primary care centre with certain clients being prepared to travel to Cork city to participate in other dual diagnosis service activities in Togher Community Centre.

The HSE's designated mental health services building on St. Patrick's Road, Cork, is located 4km from Togher Community Centre and 6km from Cork University Hospital (CUH). Some personnel on the mental health team are based here, and service-users are seen here. The wider team, including primary care addiction personnel, frequently met in this building during the inquiry process. Service-users in cycle one identified this building as being appropriately located and were comfortable meeting with the multi-disciplinary team here (see further, Cycle One chapter, p.142).

Personal/professional context of the author

My own personal life experiences have had particular influence on my participation in this inquiry. Although I am aware of hardly any mental health or addiction issues in my family, my own life experience has included both mental ill-health and addiction which has influenced my professional life. Self-medicating psychological experiences in younger years compromised my earlier education and career opportunities. Later in life, when I was able to make more informed choices, I started third-level education and became employed in the

addiction treatment field. From this collective experience, my personal and professional worlds are inseparable. This, I believe, contributes to authenticity in my working life as it does in my personal life. However, as the complexities of dual diagnosis are subjectively experienced, I am also aware that such subjectivity creates certain limitations on my engagement with others on a personal and professional level.

System variance and integration

My role in this PAR inquiry brought me into direct contact with the mental health, medical and addiction services at political, academic, management and service-delivery levels. The arena from which I entered into the inquiry was that of addiction treatment generally and primary care specifically. This section gives an overview of the variances of the mental health, the medical and addiction treatment systems, and how they are inextricably linked in the particular context of this inquiry, dual diagnosis service development (see further the Literature Review, p.25).

Attempting to access help can frequently be confusing and frustrating for individuals experiencing dual diagnosis (Phillips, 2010, p.51). Complex issues are often experienced subjectively, resulting from mental ill health and simultaneous drug/alcohol misuse, and exacerbated by external challenges emerging from the limitations and conflicting ideologies of both the mental health services and addiction treatment providers. These may include subjective issues such as fear, anxiety or paranoia, which may prohibit an individual's capability to acknowledge the urgency to seek help. Objective issues can typically include a situation where an individual needs a service but lacks information about available services and how they function. However, more fundamental external issues that can exacerbate these may include poverty, motivation, limited child care access and transportation to services (Phillips et al. 2010, pp.51-56; Kendall et al. 2011).

When people in addiction services exhibit symptoms of acute mental ill health, these are often not accurately recognised, but perceived as toxic effects from substances and/or inappropriate behaviour or, if identified correctly, as requiring referral to the mental health services. A similar process is mirrored for people in the mental health system who exhibited vivid and acute symptoms of substance dependence and/or withdrawal (Abou-Saleh and Crome, 2012).

According to Cooper (2011), rejecting, failing to recognize, or automatically re-referring people experiencing dual diagnosis can result in inadequate treatment responses, where people

cannot easily access the available services. The symptoms of mental ill health and addiction are rarely consistent and predictable, where the presentation of current symptoms frequently camouflage underlying and long-term psychological complexities. When, for example, people access and receive help from existing services, treatment may only be provided in accordance with the resources and expertise of the care provider. Therefore, where treatment is not effectively coordinated in a multidisciplinary capacity over the long-term, treatment efficacy and outcomes may be compromised (Glass et al. 2015).

Terminology

Garbare (2015) refers to the term *dual diagnosis* being interchangeably used in practice and in the literature with other terms including *co-morbidity* (Expert Group on Mental Health Policy, 2006; Department of Health, 2009a, 2009b), *concurrent disorders* (The Standing Senate Committee on Social Affairs, Science and Technology, 2004), *co-existing drug and mental health problems* (Working Group on Drugs Rehabilitation, 2007), and *co-occurring mental health and substance use problems* (Todd, 2010). For the purpose of this inquiry, I have chosen to use the term *dual diagnosis*.

Provision of Mental Health, Addiction and Medical Services

These are the three predominant treatment systems that people experiencing dual diagnosis generally encounter when engaging at various levels in a treatment process. These systems usually merge and integrate at varying stages of the process, each having its own innate strengths, weaknesses and different clinical approaches (MacGabhann et al. 2010; Hunt et al. 2013; Garbare, 2015). A broad overview is appropriate here and will also be provided in the literature review.

Mental Health Services Provision

The Mental Health Service generally consists of services provided by a broad range of mental health practitioners, including: psychiatrists, psychologists, social workers, occupational therapists, clinical nurse specialists, nurses, and many specialised therapists and counsellors. Many of these have extensive and varied clinical, academic and real-life experience of the work in which they are engaged.

Mental health personnel work in both hospital and community settings, which employ varying theories concerning the assessment and treatment of mental health issues (WHO, 2001).

Diverse mental health classifications from within the particular paradigm of psychiatry have different perspectives, which seem to change over time. Moreover, practitioners within a particular service often appear to employ varying and conflicting approaches (Vanheule, 2017, p.133).

The comprehensive suite of services available today within the mental health system include: counselling, case management and collaborative care planning, in-patient facilities and an increasing variety of rehabilitation options developed to suit the needs of service-users. The service has a wide variety of settings and options specifically structured to respond to acute, short-term and long-term symptoms. Acute services are provided in hospital emergency departments by psychiatrists and nursing crisis specialists as part of a multidisciplinary team. Hospitals provide short-term services, while community centres provide day-care options and accommodation for multidisciplinary teams. Mental health hospitals and residential mental health units provide long-term treatment, although according to the stated official policy the aim is to deliver the majority of these in community settings (Government of Ireland, 2016).

The majority of practitioners in the UK's mental health services have a bio-psycho-social approach to the screening, assessment, diagnosis, and treatment of dual diagnosis (McKeown, 2010, pp.6-11). Many, however, report deficits in knowledge and experience concerning illicit substance use and the bio-psycho-social factors of addiction. Similarly, addiction treatment professionals may have a thorough understanding of addiction treatment methodologies, but simultaneously report insufficient knowledge and experience of psychiatric treatment (Evans-Lacko and Thornicroft, 2010).

Provision of Addiction Treatment Services

Mirroring the mental health services, there appears to be no evidence of any one optimal addiction treatment response existing globally. What seems to have evolved is a diverse range of services including medical, behaviour modification and detox models, with short and long-term residential and community-based treatments, methadone maintenance facilities, twelve-step programmes and self-help community-based supports (Rotgers and Nguyen, 2006; Flores, 2007; Robinson and Reiter, 2007). There is a wide variety of treatment philosophies and programmes available, which are constantly adapting to clients' needs. Abstinence from substances, for example, may be required for access to some services, whereas for others it

may be a long-term objective. Many addiction treatment services today are not focused on abstinence, such as those embracing harm reduction approaches (IMO, 2015, pp.14-17).

Similar to the mental health service, a broad range of disciplines and practitioners are engaged in providing addiction-related services, including: psychiatrists, general practitioners (GP's), psychologists, addiction counsellors, mental health nurses and other therapists with a broad variance in experience, expertise, and knowledge (Roberts and Bell, 2013).

Addiction treatment providers generally include a multidisciplinary, bio-psycho-social and twelve-step approaches to addiction. These providers also routinely prescribe medications for addiction-related concerns, including overdose, withdrawal and maintenance. Methadone prescribing, for instance, can be important for those withdrawing from opiates, while many other options can be selected for other dependencies. However, many treatment providers may aim towards ultimately eliminating all drugs (EMCDDA, 2014).

Ancillary treatments utilised in both mental health and addiction services include; acupuncture, art therapy, mindfulness, tai chi, psychotherapy, psychoeducation (Connolly et al. 2015).

Training

Practitioners employed in various addiction settings report minimal training regarding medications required for mental health conditions. Some have reported the exclusion of medication for service-users who may have been previously dependent on prescribed medication such as benzodiazepines (Roberts and Bell, 2013). Regarding the treatment of dual diagnosis, the literature suggests an ideal balance ought to be achieved concerning behavioural strategies and the application of necessary medications for those engaged in a treatment process. Preventing access to medicalised responses for some people or excluding them from treatment processes is counter-productive and increases the prospect of relapse or disengagement from services and promotes poor confidence in the provider's understanding of services users' needs (McDaid et al. 2009; Lundgren et al. 2014).

The following social support groups are important allies to the general treatment of addiction: Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Gamblers Anonymous (GA), and Marijuana Anonymous (MA), providing critical support and guidance for people, particularly in early recovery. Such fellowships are found in most towns and cities worldwide (O'

Súilleabháin, 2014). Similarly within the realm of mental health, the following social support groups available in Ireland include: Aware, Grow, Shine, The Samaritans, and Pieta House.

Within the social context of the self-help group, however, service-users have anecdotally reported receiving inappropriate advice and/or opinions regarding medication and/or the role of medication frequently prescribed for those experiencing dual diagnosis. A relatively new fellowship called Dual Recovery Anonymous (DRA) has emerged internationally and more recently in Cork and Dublin where many service-users report this social support as meeting their needs.

General Medical Services

GPs and primary care practitioners are the initial port of call for most people with addiction and mental health problems. These personnel are particularly experienced in managing emergency situations and treating medical issues in the community. Byrne (2006) suggests that because of their contact with such large numbers of the public, they are ideally positioned to initially screen and identify people experiencing dual diagnosis.

As experienced within the context of this inquiry, GPs, and especially those located in the environment of primary care, frequently prescribe medications such as anti-depressants, anti-psychotic and benzodiazepine medications and liaise with the individual's mental health team in this regard. Furthermore, GPs and nurses focus on the medical-physical issues of addiction, such as detoxification/withdrawal or substance overdose. These issues can be managed alone or also in conjunction with referrals to specialised addiction services. More broadly in Ireland, change is being positively exhibited, where allied health care professionals within primary care teams routinely function alongside GPs, nurses, etc., facilitating effective communication regarding the bio-psycho-social components of addiction and mental ill health, particularly in the context of those experiencing dual diagnosis (IMO, 2015, pp.68-72).

Differing Approaches: Individual Responsibility and Treatment Focus

Historically, people who are referred to the mental health services, as in other areas of health care, need to attend the appointment they are given to display motivation towards change and treatment (Bailey, 2010, p.176). In practice, and also in the literature, it is recognised that many people with enduring mental health concerns are often unwilling or unable to attend appointments. In response to this, mental health practitioners have developed the case

management and care planning process to help bridge this gap. These processes aim to aid engagement and support people in a range of community-based services (Hughes, 2006, p.5).

This case management/care planning model identifies individual limitations, strengths and weaknesses, and aims to respond proactively to different needs. When, for example, a person rejects professional assistance, the case manager may often assume responsibility of employing alternative approaches to assist the person to take help, minimising at the same time any negative impact on the person. Addiction treatment personnel may view such processes as 'enabling' the individual, where many addiction services deem it necessary for the service-user to take responsibility for their actions, including attending appointments and seeking help (Beattie, 1987).

While the practices of each system may have similarities and differences, the addiction treatment system tends to focus on the individual assuming responsibility. Motivation towards change in the context of addiction is, according to Thombs (2006), often facilitated by confronting and challenging the individual about particular realities of their addiction. This challenging process may be a necessary element of the treatment process in order for the individual to reduce their denial about the consequences and behaviour patterns so entwined with their addiction. Therefore, many individuals referred to the addiction services, who either refuse help or are unable to cope with treatment approaches, may not receive help.

The treatment of people experiencing both addiction and mental ill health (dual diagnosis) must integrate both systems of mental health addiction treatment, where elements of each are appropriately accessed at stages and situations in accordance to the individual's needs. Responsibility ought to be appropriately balanced, negotiated and regularly monitored between clinicians and the service-user, with emphasis on harm reduction in the context of treatment and recovery for dual diagnosis (MacGabhann et al. 2004; Phillips et al. 2010).

Abstinence

In order to participate in treatment, many addiction treatment programmes require total abstinence from illicit and psychotropic medications. For many experiencing dual diagnosis, abstinence is often not a short-term option, and at best a harm reduction approach is favoured, similar to some methadone maintenance programs (Phillips, 2010, pp.52-53). However, the treatment of conditions, including depression and anxiety, often includes abstinence, since drug-use can compromise diagnosis and treatment. Importantly, decisions in this regard ought

to be negotiated with the individual and family member(s) where appropriate (NACD, 2004, pp.12-17).

For many experiencing dual diagnosis, suggesting total abstinence can effectively render one unsuitable for addiction treatment and may block further attempts at accessing treatment. Abstaining from or reducing substance use may be appropriate for discussion once the individual is engaged in treatment and in the context of a longer-term goal, if it is suitable to the individual. The homeless environment, for example, may not be conducive to abstaining from substances, and in this regard treatment providers ought to consider the individual's bio-psycho-social needs, particularly on initial engagement (MacGabhann et al. 2004, pp.36-40; Phillips et al. 2010, pp.51-56).

Overview of Chapters

Chapter Two contains a review of the literature relevant to the field of dual diagnosis. Harte (1998) outlined the pertinence for a literature review in order to provide a historical context for a dissertation. This, Harte contends, leads into the necessity to review current literature concerning the area being studied. In the collective review of the historical and current context of a body of knowledge, he suggests that the identification of matters of concern equally ought to be included in the review.

The structure of the literature review starts with the historical response to addiction in Ireland, followed by the evolution of concepts and language concerning the co-occurrence of addiction–substance use and mental ill health concerns (dual diagnosis) experienced by an individual. From this, the roles of psychiatry and psychiatric classification systems in the context of diagnosis are discussed. Following this, dual diagnosis prevalence and epidemiological studies are reviewed, as are the development and employment of particular screening and assessment tools. This is followed by a review of psychoanalytic and psycho-social perspectives as they relate to dual diagnosis. The chapter ends with a discussion of the methodologies employed in the literature reviewed.

In Chapter Three, the choice of the methodology is outlined. To inform that methodological choice, the historical evolution of research paradigms is overviewed, including positivism, post-positivism, interpretivism, critical theory and pragmatism. From this, the principles, characteristics and challenges of action research are introduced. This leads into the chosen

methodology, participatory action research (PAR), its worldview and the philosophical framework adopted for this inquiry.

In Chapter Four, the methods of data-gathering and analysis that the methodological approach enables are discussed, including qualitative individual and focus group interviewing, participant observation and reflective journaling. Methodological rigour and theoretical development are then discussed.

Chapters Five, Six and Seven concern the research inquiry Cycles, and are presented in the cyclical format consistent with the methodological approach. Consistent with the methodology, and for presentation purposes, I present throughout the three chapters my personal reflexivity, analysis and theorising, beyond that of co-participant analysis, in boxed headings entitled *Theoretical Insights*.

Chapter Five, Cycle One, illustrates the reflective, planning, action and observation phases of engaging stakeholders in a participatory reflective process to enact service developments. From this, the processes of data collection and analysis are presented. This is followed by a discussion of the initial percepts that contributed to the evolution of a practical theory, from which a philosophical and theoretical discussion evolved.

Chapter six, Cycle Two, illustrates the methodology's cyclical processes relevant to the objective of collectively embedding into practice those service developments that had taken place in Cycle One. The methods of data collection and analysis are presented, followed by an illustration of the philosophical underpinnings that mobilise and help shape the theoretical development. In this, the discussion includes the refinement of the initial percepts that informed the modified practical theory shaping the evolution of the dual diagnosis service.

Chapter Seven, Cycle Three, likewise illustrates the experiences of the dual diagnosis service integration, where two case studies outline service-user experiences of the developed dual diagnosis service. The methodology's cyclical processes are presented as in previous Cycle chapters, while the amalgamation of former and emerging percepts further modify the development of the practical theory. In this, demonstrations of system transformation permeate the chapter.

Chapter Eight critically discusses the inquiry process and its implication for practice concerning dual diagnosis service delivery. The practical and theoretical contribution to

knowledge and how this relates to organisational dynamics are discussed. The percepts that emerged over the inquiry process, and how these relate to the process of service development over the three Cycles of inquiry is discussed. This is followed by a theoretical discussion on participation as a process in PAR, leading to discussion on 'dual diagnosis' as a concept and as a feature over the inquiry. Developing this service within competing discourses/paradigms is discussed, followed by the adoption of PAR in an organisational development context.

Chapter Nine gives an overview of the inquiry/service development process, with additional concluding commentary.

CHAPTER TWO: LITERATURE REVIEW

Some of the classical social analysts, including Auguste Comte, Emile Durkheim, Herbert Spenser and Karl Marx, have expressed an imagination and creativity in their repective works over many decades while faultlessly displaying a unique resourcefulness to '*grasp history and biography and the relations between the two within society*' (Wright Mills, 1978, p.6). Allowing myself as a novice researcher to have an open mind while imaginatively and creatively exploring the literature has evoked many questions. Some of these have a particular relevancy, and I have attempted to respond to them during the process of this review, while others with somewhat lesser specificity may not be included.

Some of the broader questions to emerge in this review include: What is the structure of Irish society today? What are its components? How are they related to each other? Within these structures are there possibilities of development or change for the better? If change is desired, what methodologies are best suited to bring this about?

In order for me to look at myself and the organisational system I am inevitably a part of and in which I am participating in an active process of change, it is necessary for me to firstly explore the historical perspectives and varying contexts that have shaped that system up to today and which inevitably will shape it in the future.

> '*It is not to see something first, but to establish solid connections between the previously known and the hitherto unknown, that constitutes the essence of scientific discovery. It is this process of tying together which can best promote true understanding and real progress*'.
>
> Hans Selye (1950, p.4)

The different aspects of the literature which I researched included the broad subject area of dual diagnosis, the origins of psychiatry in Ireland, the origins of addiction services in Ireland, terminology and meaning, causation and prevalence, assessment and screening, policy and service development, and what methodologies have been employed in the development of services relative to dual diagnosis. Much of what has been reviewed and discussed will be linked throughout to the 'Methodology' and 'Methods' chapters as appropriate.

Information on previous and current works in these broad areas was located using the Google and Google Scholar search engines. Electronic databases accessed included: American Medical Association (AMA), BioMed Central, Cambridge Journals Online, Cochrane Library, Emerald management Xtra, ERSI Reports, Psyc Articles, PsycInfo, PubMed, SAGE Journals Online and Wiley Online Library. The review also included literature sourced in relevant books, journals and multiple websites relevant to the particular topical areas and perspectives. Other materials, such as conference papers, reports and theses, were identified using a variety of other sources available from the reference sections in DCU and UCC libraries, including: Government of Ireland reports, the respective American and Canadian government and administration reports, Substance Abuse and Mental Health Services Administration (SAMHSA) reports, Australia and New Zealand Government and national reports, national reports from Asia and the Middle East, India, Iran, China, Taiwan, Pakistan and Israel, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) reports, government reports from European countries, including Ireland, the United Kingdom, Norway, Sweden and Denmark. France, Germany, Italy, Spain and The Netherlands.

The initial general database search or 'sweep' produced thousands of 'hits'. The initial issue of having too much data to read within a specific timeframe for the review, plus the cost of purchasing books and of inter-library loans, culminated in a decision to identify and select books and articles considered by the respective disciplines/communities to be the key works and sources associated with the topical areas of dual diagnosis. However, this narrowing of materials still resulted in hundreds of potentially relevant books and articles on the list. To read all these would not be possible within the timeframe, but what was feasible was to read all the associated abstracts and to then select those items which were clearly relevant. As has been observed before, developing research skills requires '*to know when you ought to read, and when you ought not to*' (Wright Mills, 1978, p.236).

By simultaneously exploring the two broad areas of the historical context of addiction (traditionally linked to alcoholism in Ireland) and associations to mental health, and the evolution of research approaches which led to the choice of PAR for this inquiry, the particular subject areas/headings emerged as the review process unfolded.

Society's historical response to addiction in Ireland

Throughout the nineteenth century problem drinkers in Ireland were subjected to a variety of institutional regimes aimed at punishing them for their behaviour or curing them of what was sometimes described as a disease (Butler, 2002; Prior, 2017). Contrary to the growing emphasis at that time within custodial institutions on the increased role of expert knowledge and institutional differentiation in societal management of '*deviants*', attempts to categorize and segregate problem drinkers failed in their attempts to bring ideological or organizational clarity to what was referred to as *habitual drunkenness*, *inebriety* or *dipsomania*. During this period the penal system processed large numbers of people, predominantly men whose criminal behaviour was alcohol-related. Also at this time the creation and development of the *lunatic asylum* system provided an alternative ideological and institutional framework for the public management of problem drinkers. This would suggest a high incidence of mental illness and drunkenness in Ireland at that time, though most writers on this topic suggest that it reflected the vagueness and ambiguity of the broad concepts of *insanity* and *lunacy* and that the *lunacy asylum* system in Ireland was simply a generous host to an assortment of '*difficult, disabled and generally deviant*' people, all of whom were involuntarily detained (Butler, 2002; Higgins and McDaid, 2014).

The original establishment of *lunatic asylums* in Ireland and other countries took place without any reference to the medical profession, which was seen as neither possessing the scientific capacity to identify precisely the particular problems of those who were institutionalized, nor having a legitimate claim to a leadership role in the management of the institutions (Higgins and McDaid, 2014; Kelly, 2016). Butler (2002) further asserts that the management of asylums was initially placed in the hands of lay people and was based on the concept of *moral treatmen*t, a notion suggesting that those whose behaviour was disturbed and disturbing could be rectified by being treated *morally*, for example, *'with kindness and ordinary human consideration*' (p.174). However, the medical profession gradually lobbied to have lunacy seen as a mental illness or disease that was amenable to medical treatment, and thereafter to have asylum management regarded as a medical monopoly (Scull, 1979; Finnane, 1981; Kelly, 2016; Prior, 2017). Regarding moral treatment, Foucault (1964) argued that *'external chains had been replaced by internal repression*' (p.68). Although his historical accuracy may have been questioned, he suggests that the motivation for moral therapy, while expressed in

terms of humaneness, lay in its effectiveness in establishing control. Scull (1989, p.89) summarizes Foucault's point: moral treatment actively sought to change the mad-man, to transform him into an individual much more acceptable to high class society. From this viewpoint, the concern with such external forces was that it might engender the conforming of one to society, but neglect the internalisation of moral standards. From the mid-nineteenth century onwards, lunacy management in Ireland (as elsewhere) resided firmly in the grips of the medical profession (Kelly, 2016; Prior, 2017), giving rise to the emergence of the modern specialism of psychiatry, while asylum attendants moved somewhat more slowly towards the professional status of psychiatric and, more recently, mental health nursing (Walsh, 2012; Prior, 2017). This displacement of the '*moral managers*' by doctors reflected a fundamental shift from a moral to a scientific approach. The medical profession had succeeded in persuading government (and perhaps also the public) that the deviant anti-social behaviour and irrationality of the asylums inmates was in fact a form of illness, the underlying causes of which would sooner or later be revealed by scientific research, thereby leading to technically effective treatment.

Since this 'mental illness' primarily affected the rational faculties of its '*victims*', it was not surprising that frequently they failed to recognize their need for treatment and so had to be compulsorily detained and treated. However, the historical and social science literature is virtually unanimous that this medicalization of '*lunacy*' resulted from the political skills and relatively high status of medicine within nineteenth century society (Kelly, 2016; Prior, 2017), rather than from any demonstrable scientific progress or evidence of effective treatment technologies at this time. Two centuries later, the medical model of '*mental illness*' and the legitimacy of the medical grip or ownership is still greatly contested (*A Vision for Change*, 2006, Chapter 2; Higgins and McDaid, 2014; Kelly, 2016; Prior, 2017).

The management of alcohol-related problems within the asylum system, however, seemed to create a sense of unease in relation to the relatively smooth transition from a moral to a scientific model of management. Valverde (1997,1998) who has studied the management of alcohol problems within the asylums of nineteenth-century Britain and North America, concluded that the attempt to medicalize alcoholism failed and that this failure primarily because it was thought alcoholism involved a *'disease of the will*' rather than a *'disease of the mind*'. In other words, problem drinkers, when sobered up, appeared to asylum staff to be

quite rational and thus quite different from other inmates. For this reason, there were persistently recurring debates as to whether problem drinkers should be categorized as lunatics at all and managed in the asylums, or whether they would be more appropriately categorized as criminals and managed by the courts and prison system. Underlying this was a fatalistic belief that scientific medicine could do nothing to alter destructive drinking patterns if the persons involved did not wish to change. In this regard there is little evidence to suggest that the approximate ten per cent (Finnane, 1981) of admissions to the asylums for alcohol-related behaviour at the end of the nineteenth-century in Ireland achieved anything other than some respite for the drinker, their family and the community. Of note was the much more frequent admission and discharge cycle of this drinking population than other inmates, a pattern ironically later described and associated with the dual-diagnosed population as the *'revolving door*' phenomenon (MacGabhann et al. 2004, pp.50-51; Daly et al. 2010).

If the medical gatekeepers and staff were ambivalent about the legitimacy and effectiveness of trying to cure *'inebriates*' or '*habitual drunkards*' within the Irish lunatic asylum system, then prison authorities were equally unconvinced of the value of constantly restraining such drinkers in the prison system. Smith (1989) notes that as late as 1895 the General Prisons Board estimated that at least half of their prisoners were '*habitual drunkards*'; in this regard it is clear that that this burden was far greater for the prison system than for the asylums. Following public and parliamentary debate involving religious temperance groups and prison authorities, the British Parliament enacted the Inebriates Act of 1898 which provided for the establishment of yet another form of institution known as the inebriate reformatory. It was neither a prison nor an asylum, but it represented the first attempt at specialist treatment for problem drinkers. In Ireland, a state inebriate reformatory was opened under the aegis of the General Prisons Board in Ennis in 1899, with two more opening in Wexford and Waterford soon after (Bretherton, 1987). In these, as in similar institutions in England and North America (Johnstone, 1996), the aims were expressed idealistically in relation to the moral reform of inmates deemed to have lost control of their drinking. It was hoped that through the experience of a structured and highly disciplined regime that inmates would rebuild their wills, so that when discharged they would remain alcohol-free. The Irish experience was no different to that of any other country in that this system was no more successful than the asylum or the prison systems, and by the time of the formation of the Free State in 1922, all the inebriate

reformatories were closed (Prior, 2017). Around this time, attitudes towards people deemed to be '*habitual drunkards*' remained ambiguous and contested, and institutional responses to the problem drinker reflected these attitudes. According to Smith (1989), there appeared to be a broad consensus that socially disruptive drinkers should be subjected to institutional confinement, if only to deprive them of access to alcohol, but agreement could not be found on which type of institution was most appropriate.

Methodologically, the literature reviewed in this section illustrates the approaches to research employed which were predominantly remote, thereby establishing distance between the researcher(s) and those being researched.

The Evolution of the Addiction and Addiction Treatment Concept

From the Latin word *addicere*, *addict* was originally a legal term, according to Shipley (1945, p.377), meaning by sentence to the court; an *addict* is thus bound to or given over to (figuratively, to a habit).

The Mental Treatment Act, 1945, which remained in force until 2006, was of great importance to Ireland's evolving mental health system (Prior, 2017, p.xxvi). It provided for the voluntary admission of people to institutions which were coming to be referred to as mental hospitals and which set in place a rudimentary system of legal safeguards against wrongful or unnecessary detention in these institutions. It also provided a statutory basis for the development of a range of outpatient psychiatric facilities, although many were not developed for another twenty years. In relation to the management of '*inebriates'*, the Mental Treatment Act was important because it specifically provided for both the voluntary and involuntary admission to hospital of '*addicts'*.

In this Act, the word addict means a person who is*:*

> *'By reason of his addiction to drugs or intoxicants is either dangerous to himself or others or incapable of managing himself or of ordinary proper conduct, or By reason of his addiction to drugs, intoxicants or perverted conduct is in serious danger of mental disorder.'* (Mental Treatment Acts 1945-1961: Explanatory Notes, Part B, Section 3, Dublin: Statutory Office, Journal of the Medical Association of Eire, 1945, p.114).

This inclusion of addiction to drugs or intoxicants as a form of pathology which might appropriately be dealt with within what was now being described as the mental health system occurred at a time when the so-called disease concept of alcoholism was being heavily promoted in America. It might therefore be inferred that Irish policy on the management of problem drinkers was finally and unequivocally coming down on the side of the medical model. Such an inference is not supported by a study of the background to this legislation; however, this may suggest that support for the treatment of alcoholism/addiction within the mental health system was at this time tentative and equivocal.

The Mental Treatment Act (1945) provided a statutory basis for the admission and treatment of addicts and, along with the growing acceptance of the disease concept of alcoholism and addiction, led to the emergence of the mental hospital as the preferred location for dealing with addiction problems in Ireland (Walsh, 1987). By the mid-1980s these admissions accounted for a quarter of all annual admissions to Ireland's mental health system (for such statistics and a discussion of the burden which addiction had become for the mental health services, see Chapter 13, 'Alcohol and Drug-Related Problems' in *The Psychiatric Services: Planning for the Future*, 1984).

The terms *'alcoholism', 'alcoholic'* and *'addict'* were being used in the mid-1940s in Ireland; however, the use of such terminology was not met with a resolution to the management of those whose drinking related behaviour was continually disruptive in society. Sociologically, ownership of such problems was still very much a contested issue, with disagreement as to whether these people should be categorized as victims of a disease and processed via health care institutions, or as weak willed '*degenerates'* who should be processed via criminal justice institutions or even exposed to some kind of religious reformation (Gusfield, 1996). Psychiatrists seemed ideologically unconvinced that alcoholism was a genuine mental illness for which there was any useful remedy; while judges, guards and prison authorities were equally unconvinced of the value of processing alcoholics via their institutions.

In 1946 Alcoholics Anonymous (AA) arrived in a country that had avoided the extremes of Prohibition, but in which the management of alcohol and drug-related problems continued to be a highly contentious health and social concern. In a book on the disease concept of addiction, Jellinek (1960) notes:

> *'Around 1940 the phrase 'new approach to alcoholism' was coined, and since then this phrase has been heard again and again, every time that the Yale Centre of Alcohol Studies, the National Council on Alcoholism, Alcoholics Anonymous or individual students make an utterance to the effect that alcoholism is a disease.'* (p.45)

An additional variant of the disease concept evolved in the USA with the development of the *Minnesota Model* (Anderson, 1981) which arrived in Ireland around 1980. This treatment model represented a professionalization of the philosophy and methodologies of the AA programme of recovery, but was nevertheless fundamentally different to the AA in its development of highly structured residential and non-residential treatment programmes, which are still being delivered today throughout Ireland (Keane et al. 2014).

Language and terms of reference

Mental health issues are a common feature among those availing of addiction services in all countries across the world. An understanding of the co-occurrence of psychological and substance use issues has evolved over the past thirty years with (a) the development of diagnostic criteria to help recognize this co-occurrence; (b) shifts in theoretical paradigms; and (c) consequences of social trends, including the widespread availability of drugs and acceptance of drug use and the deinstitutionalisation of people from in-patient mental health facilities into community settings (Wittchen, 1996; Baldacchino and Crome, 2011). However, as this section describes, increased levels of understanding of 'dual diagnosis' has resulted in the development of a number of appropriate services in some countries to respond to this need. Despite access to such data, apart from this inquiry and local responses in some addiction and mental health services, little has emerged in either public health policy or in the specific provision of dual diagnosis service in Ireland (MacGabhann et al. 2004, 2010; Connolly et al. 2015).

When mental illness and substance misuse concurrently impacts an individual's general health and social world, this frequently challenges possibilities for the allocation and provision of appropriate interventions. (Darke et al. 1992; Weiss et al, 1992; Blanchard, 2000; Johnson, Brems and Burke, 2002; MacGabhann et al. 2004; Watkins et al. 2004; Rush, 2008; MacGabhann et al. 2010; Hunt et al. 2013; Connolly et al. 2015). The experience of two mental health 'disorders' by an individual, is varyingly referred to in the literature as *comorbidity*, *co-occurring disorders* or *dual diagnosis* (National Institute on Drug Abuse,

2008). The term *disorder* is used frequently in this review, reflecting the frequent use of the term in the literature; further, the terminology employed here again reflects what is encountered in the literature, rather than my choices.

Comorbidity is defined by Feinstein (1970, p.467) as 'any distinct additional clinical entity that has existed or that may occur during the clinical discourse of a patient who has the index disease under study', with more contemporary definitions describing the 'co-occurrence' of mental health 'disorders' (Boyd et al. 1984; Burke et al. 1990). The World Health Organisation (1995) defined comorbidity as the 'co-occurrence of a psychoactive substance use disorder and another psychiatric disorder' (p.7). Critics suggest such terms as being vague and loose in their attempt, in the absence of explicit diagnostic classifications, to classify what is a heterogeneous population with often complex needs (Van Den Akker, Buntinx and Knottnerus, 1996; Wittchen, 1996; Banerjee, Clancy and Crome, 2002). Conceptually, 'comorbidity' has emerged as a general term for describing varied links between groupings of symptoms related to one's mental health (Weiss et al, 1992; Wittchen, 1996; Flynn and Brown, 2008).

The terms *dual diagnosis, co-occurring disorder* and *comorbidity* employed in the literature refer to the co-occurrence of mental ill health and substance misuse. The terms vary according to culture and profession, which may influence their application in clinical practice. Of note, the efficacy or benefits of such terminology is deemed useful within the realm of the literature, though questions frequently emerge concerning their efficacy in clinical practice (Weiss et al. 1992; Wittchen, 1996; Chambers, 2008, Toneatto, 2008; Bartu, 2009; MacGabhann et al. 2010; Roberts, 2010; MacGabhann et al. 2010; Baldacchino and Crome, 2011; Guest and Holland, 2011).

Cooper (2004) argues against the inappropriate use of *comorbidity*, pointing out that the word 'morbid' suggests 'disease', thus making the term unsuitable for describing 'psychiatric disorders'. The author notes the difference between 'disease' and 'disorder', and asserts that clinicians work on the basis of identifying 'disorders' and groups of symptoms that are linked with particular 'disorders' as opposed to considering the underlying causation. Additionally, service-users report the experience of such terminology by practitioners in their engagement with mental health services as stigmatising (MacGabhann et al. 2004, 2010; Corker et al. 2013; Garbare, 2015).

Maj (2005, 2006) contends that the term is inappropriate for the co-occurrence of two or more 'psychiatric disorders', particularly when relying on scant data about causation and the lack of knowledge concerning the co-occurrence of symptomology resulting from 'distinct clinical entities' or one 'single clinical entity'. He argues that the current diagnostic system of separating symptomatology into categories of discrete disorders, referred to as 'diagnostic splitting' is inappropriate and misleading (Wittchen, 1996; Blanchard, 2000; Pincus, Jew and First, 2004; Maj, 2005, 2006; Tew and Pincus, 2007; Flynn and Brown, 2008; Todd, 2010). Interestingly, an aspect of psychiatrists' training, according to Phillips (2006), shows how psychiatrists are trained to observe appearance, dress, bearing, gesture and mannerisms, without any formally organized basis of evaluation. Phillips suggests that they take account of such as '*deviations from conformity rather than read them as an attempt at communication*' (p.87).

Suggestions that the terms 'dual diagnosis', co-morbidity' and 'co-occurring disorders' are increasingly being questioned, stems from a disease and a duality-based interpretation of psychiatric disorders, which ignores the complex range of underlying psychological, physical, social and traumatic concerns experienced by people (Drake and Wallach, 2000; Ronis, 2008; Bartu, 2009). Psychosocial and phenomenological models assume a contrasting approach; the psychosocial looks at familial, social and community aspects of one's life, the phenomenological approach stresses the significance of both one's experience and insight into such and in participation in decisions about one's treatment. (Drake and Wallach, 2000; Toneatto, 2007). These alternative approaches underline the need to revisit policy development and implement specific support in people's own community (such as this service development/inquiry) in order to address fully the complex nature of co-occurring problematic substance use and mental ill health (MacGabhann et al. 2004, 2010; Connolly et al. 2010, 2015).

Discrepancies in language or terminology are also prevalent in the use of the terms 'co-occurring disorders' and 'dual diagnosis'. For example, co-occurring disorders are identified as the co-occurrence of substance-use disorders and mental illness, while 'dual diagnosis' is linked with the description of co-occurring mental illness and intellectual disability (Graziano, 2002), although the term is often used to describe co-occurring substance-use and mental illness (Chambers, 2008; Drake and Wallach, 2000). The World Health Organization defines

‘dual diagnosis’ as ‘*a person diagnosed as having an alcohol or drug abuse problem in addition to some other diagnosis, usually psychiatric such as mood disorder or schizophrenia*’ (WHO, 1995, p.56). This lack of coherence over the use of these terms is puzzling and illustrates discrepancies between government departments and treatment providers worldwide. In Ireland, both the mental health and addiction services appear to consistently use the term ‘dual diagnosis’ to describe the co-occurrence of substance-misuse and mental health concerns (Drugnet Ireland, 2005; Government of Ireland, 2009; MacGabhann et al. 2004, 2010).

Kirby and Keon (2004) define co-occurring disorders as *‘a combination of mental, emotional and psychiatric problems that occur with the abuse of alcohol and/or psychoactive drugs*’ and differentiate between: 1) co-occurring disorders at the same time; 2) co-occurring disorders in the recent past; and 3) co-occurring disorders that occur at different stages during a person’s lifetime (p.8). The term ‘concurrent disorder’ is also employed within the Canadian mental health services to describe the occurrence of substance-use and psychiatric disorder at the same time, but it is rarely used in clinical contexts outside of Canada (Kirby and Keon, 2004). Teeson and Proudfoot (2003) differentiate between concurrence and comorbidity, asserting that concurrence suggests the ‘*clustering of psychiatric disorders over a period of time*’, while comorbidity includes the co-occurrence of historical and current disorders.

Ambiguity also exists in the inclusion of serious mental illness under the concept of ‘comorbidity’. In the Canadian mental health system, for example, the term ‘co-occurring’ disorder is used when describing the co-occurrence of serious mental illness and co-morbid substance use (Rush et al. 2008), while in the same system the term ‘dual diagnosis’ has frequently been referred to as the co-occurrence of severe mental illness and substance misuse (Drake and Wallach, 2000). This language ambiguity undoubtedly upholds the segregation of relevant services, where those deemed mentally ill with substance use issues are referred to the mental health services, and those experiencing personality disorders and substance use issues are referred to addiction services (Flynn and Brown, 2006; Bartu, 2009; Baldacchino and Chrome, 2011). Such discrepancies and ‘*the lack of consensus on what dual diagnosis actually is*’ (MacGabhann et al. 2004, p.3) is further confused by the inconsistent use of the terms ‘co-occurring disorder’, and ‘comorbidity’ (Hamilton, 2014) which has resulted from shifts in definitions, multiple meanings (Roberts, 2010) and cultural influences.

Dissatisfaction is also evident in the lack of specificity in the meaning and definition of 'dual diagnosis'. McKeown and Derricott, 1996, Rostad and Checinski, 1996 and Abou-Saleh, 2004 have collectively identified concerns with the adoption of such conceptual terminology, particularly in relation to the assessment and treatment of a complex population. Likewise, language employed within contemporary policy documents also reflects the shift from 'dual diagnosis' – 'co-morbidity' – 'co-occurring disorders', to that of 'complex needs' (SAMHSA, 2013, 2014).

Other approaches distinguish comorbidity in accordance with the specific timeframe when the co-occurring disorders emerge. Angold, Costello and Erkanli (1999), for example, distinguish between 'concurrent' and 'sequential/successive' comorbidity, suggesting that concurrent comorbidity describes the simultaneous co-occurrence of two or more psychiatric disorders, while sequential comorbidity describes the occurrence of two or more disorders not emerging simultaneously. With this approach, the authors emphasise the function of possible underlying familial, developmental and social factors contributing to the emergence of a broad range diverse mental ill health concerns.

Angold et al. (1999) further suggest that homotypic comorbidity refers to the co-occurrence of psychiatric disorders within a homogeneous diagnostic grouping, such as the co-occurrence of two substance-use disorders, while heterotypic comorbidity refers to the co-occurrence of two disorders from different diagnostic categories such as the simultaneousness of substance-use, anxiety, or mood disorder. Fundamentally, this concept appears to differentiate between the origins of similar or different disorders and further considers the influence which varied and multiple underlying factors may contribute to the clinical picture over time.

The literature appears to signal a shift from a corrective approach concerning radical changes in a person's life or psychological makeup to a preventative approach located in the identification of an individual's current challenges which may protect against future vulnerabilities. This appears to be a trend in the literature in this and the following section, where individual and group profiling for dual diagnosis appear to a dominant feature. This theme seems to eclipse research conducted on the traumatic/subjective experiences which may have contributed to the individual's experience of dual diagnosis, suggesting a potential gap in the literature in this regard. Furthermore, considering the methodological approaches chosen in the literature reviewed in this section, positivist approaches seem to have been

predominantly employed, which seems to establish a distinct distance between the researcher and the researched.

Also, while the contemporary literature reflects a shift in language, the challenges associated with multiple perspectives on diagnosis and on terminology may likely remain. In particular, this shift may influence research and discourse development as more participatory approaches to diagnosis, assessment and service response emerge for this cohort.

The co-occurrence of mental health and substance use, categories and groupings

A psychiatric disorder is defined by the American Psychiatric Association as '*patterns of behaviour or thoughts that are associated with distress, disability or adverse events such as death, and can occur as a result of behavioural, psychological or biological dysfunction within an individual*' (American Psychiatric Association, 2000, p.7). Holt et al. (2007) suggest such conditions may significantly disturb someone's life and manifest as mood disorders, substance misuse, anxiety, with normal thought distortions diminishing cognitive, psychological and normal inter-personal communications. According to Holt et al., this shows the lumping together of difficulties assumed by the APA to be structural, including '*disability*', and '*biological dysfunctional*' conditions, and those that acknowledge the transitional, including those associated with '*adverse events*'. This confusion has major implications, for example, in diagnosing 'something *wrong* with the client' rather than a set of current circumstances involving loss/distancing of supports, disorientation, shock precluding corrective rebalancing and difficulties regarding articulation. It also fails to recognise that it is the latter (transitional) difficulty, the circumstantial rather than presumed psychopathological emergence of a problem that offers a therapeutic opportunity.

The *Diagnostic and Statistical Manual of Mental Disorder* (DSM), published by the American Psychiatric Association, and the *International Classification of Diseases* (ICD), published by the World Health Organization, have a particular language which many mental health professionals' access and use when forming a psychiatric diagnosis (American Psychiatric Association, 1994). Within this discourse, such conditions appear to vary in the context of their categories or groupings according to the severity of particular symptoms and the impact on the individual's life. Interestingly however, the DSM-IV also states that '*the concept of*

psychiatric disorder lacks a consistent operational definition that covers all situations' (American Psychiatric Association, 1994, p.14).

The DSM-IV and ICD-10 cite drug abuse and substance dependence as psychiatric disorders. Within the American Psychiatric Association's manuals, substance use disorders are categorised as patterns of misuse which may negatively influence someone's personal and working relationships, general health and financial world (American Psychiatric Association, 1994).

DSM-IV states in relation to substance dependence: '*When an individual persists in use of alcohol or other drugs despite problems related to the use of the substance, substance dependence may be diagnosed. Compulsive and repetitive use may result in tolerance to the effect of the drug and withdrawal symptoms when use is reduced or stopped*'. (American Psychiatric Association, 2000, p.35).

According to National Institute on Drug Abuse, substance dependence is linked to physiological symptomology, though frequently diagnosed in the absence of dependency. Alternatively, the term substance abuse is adopted when someone is cognisant of negative effects from using substances though lacking evidence of uncontrollable use or symptomology related to the withdrawal of the substance(s) used (National Institute on Drug Abuse, N.I.D.A., 2008).

Revised editions of the DSM and ICD manuals feature the condition 'psychiatric comorbidity' which appears to differentiate from the 'one disease one diagnosis' category listed in the DSM-1 and DSM-11. For example, '*The general convention in the DSM-IV is to allow multiple diagnosis to be assigned for those presentations that meet criteria for more than one DSM-IV disorder*' (American Psychiatric Association, 2000). This encourages clinicians to gather large amounts of clinical information which may contribute to the ultimate diagnosis made and which in turn may also inform the assessment and treatment processes. In practice, however, clinicians appear to be frequently under-resourced, which may inhibit the ability to glean comprehensive or pertinent data, especially when relying largely on such diagnostic criteria. This process may also negatively impact on appropriate referral pathways and treatment if solely confined to the realm of these 'psychiatric' guidelines.

The DSM-V, V and ICD-10 classification structures

Mental health and addiction diagnoses are formulated according to criteria within the DSM-V and ICD-10 classification systems. The DSM-V multiple-axial structure, for example, functions on the basis that a complete assessment must also consider an individual's physical health and the psychological and social factors influencing them. This diagnostic structure includes mental health conditions referred to as 'Axis 1 disorders', developmental conditions referred to as 'Axis II disorders' and Axis III conditions such as physical ailments. Concerns associated with psychological stress are listed within the structure of 'Axis IV', and the 'Axis V' section includes an individual's general coping capabilities (APA, 2013, Vanheule, 2017).

The revised DSM-V states that where there is more than one mental health disorder, the predominant diagnosis is focused on initially. Within this clinical structure, practitioners are advised to deviate from an Axis II diagnosis when someone may be experiencing an Axis I listed concern. The ICD-10 classification structure functions on a similar basis to the DSM-V, suggesting that practitioners take note of as many symptoms and diagnoses as necessary to capture the complete presentation. This approach appears to focus on identifying a principle diagnosis with additional though less significant diagnoses also provided. This seems to suggest that the principle diagnosis is ordinarily the issue which precipitated the person's attendance for assessment (WHO, 1994; APA, 2000, 2013; Vanheule, 2017).

Considering substance use, the DSM-V describes 'primary' or 'substance induced' conditions and specifies intoxication and withdrawal as consequences frequently to be expected with such presentations. A diagnosis of a primary condition is provided if it is established that the presenting symptomology is not directly due to physiological effects of a substance(s); and a substance-induced condition may be diagnosed only when the principle concern has been eliminated (Samit et al. 2004; Vanheule, 2017). According to the DSM-V, the following four conditions determine whether or not a mental health crisis coincides with substance intoxication or withdrawal and should be then categorised as a primary condition:

- *symptoms considerably exceed what is generally expected considering the type/amount of the substance used and/or the duration of use;*
- *a history of presentations which are not substance related;*
- *the emergence of symptoms which precede substance use;*

- *the symptoms remain for at least a month after detoxification and/or substance withdrawal* (APA, 2013, p.342).

Substance induced disorders are differentiated within the ICD-10 categorisation according to the effect of the type of substance used, for example, a mental health 'disorder' resulting from the use of alcohol. Intoxication and withdrawal conditions are also classified in this framework according to the presentation of particular physical and/or psychological conditions.

Where people present with historical and ongoing substance use, the ICD-10 methodology includes a range of assessment procedures which assist practitioners with the challenging diagnostic process of distinguishing between (a) the substance withdrawal effects and (b) the primary and substance induced conditions.

Poly-substance use conditions

The simultaneous use of numerous substances coinciding with mental health conditions is broadly described in the ICD-10 as a mental health and/or behavioural condition resulting from multiple drug use. The DSM-IV likewise refers generally to the diagnosis of poly-substance dependence and mental health disorder emerging from the chronic use of multiple substances over an extended period (APA, 2000). Further, considering such vague definitions, potentially significant behavioural or psychosocial or traumatic factors do not appear to be considered in these diagnostic approaches relative to poly-substance use, many of which may frequently emerge in screening interventions.

Screening

Screening is defined as a function which measures if a person requires further assessment in relation to a particular condition(s) (Centre for Substance Abuse Treatment, 2005, p.4). The screening process assists the practitioner in establishing the existence of dual diagnosis or other conditions, though it does not determine a specific diagnosis (Sacks, 2008).

In this regard, the screening process differs considerably from the assessment procedure, whereby screening establishes the possibility of someone experiencing a substance use and/or other mental health condition, while the assessment aims to determine the particular features of the presenting condition via a comprehensive interviewing process which may contribute to the formulation of the dual diagnosis pathway of care (SAMHSA/CSAT, 1993, Centre Addiction Mental Health, 2006; Todd, 2010; SAMHSA, 2013, 2014).

Practitioners have widely reported that dual diagnosis can be challenging both to screen for and to diagnose clearly. Best practice guidelines for dual diagnosis screening internationally propose the necessity of a global screening of substance-use conditions within all mental health services and of mental health conditions across all addiction treatment providers (Lehman et al. 1989; Substance Abuse and Mental health Services Administration, 2002; Kavanagh et al. 2003; Teeson and Proudfoot, 2003; Centre for Substance Abuse Treatment, 2005; Castel et al. 2008; Crome et al. 2009; Todd, 2010; DeVido and Weiss, 2012; Yager, 2015).

In mental health or addiction services, the screening process per se, according to Sacks (2008), may be interpreted by the service user as a positive intervention by the practitioner to begin to explore their particular context and determine an appropriate treatment plan. Alternatively, Parikh (2008) highlights the fact that the screening process may provoke defensiveness when considering the fear of stigmatisation frequently linked with addiction and mental health diagnoses. In this context, Parikh further emphasises the importance of establishing rapport, particularly as the screening process may be the person's initial point of contact with services.

Another qualitative-descriptive study exploring clients' perceptions of screening found initial unease and scepticism amongst participants while discussing subjective feelings and experiences, though outcomes from the same study cited that these feelings improved when practitioners explained the objective of the screening process in detail (Kirk, 2007).

Outcomes from the screening process in the context of dual diagnosis, according to Baker and Vellerman (2009), ought to illustrate an individual's functioning capabilities concerning their physical, social and occupational realms. Sacks (2008) suggested that an individual's cognitive and literacy abilities are factors to note when considering service-user comprehension of the screening process.

Screening tools

A variety of screening tools are adopted by mental health and addiction services, and the particular selection of one over another appears to depend on a number of matters, including: finance, availability, appropriateness and the training needs. They are classified either as general mental health tools, which measure a broad range of conditions, or specific mental health tools, which measure the symptoms of one particular condition (Rush et al. 2005). The following instruments are employed as general screening tools:

- Brief Symptom Inventory (BSI)
- Symptom Checklist-90-revised (SCI-90)
- Kessler Psychological distress scale (K6)
- Psy-Check screening tool
- Brief Psychiatric rating Scale (BPRS) and
- Psychiatric Diagnostic Screening Questionnaire (PDSQ)

Specific screening tools include:

- Becks Depression Inventory (BDI)
- Becks Anxiety Inventory (BAI)
- Hospital Anxiety and Depression rating scale (HADS) and
- Hamilton Rating Scale for Depression (HRSD)

Both in the addiction and dual diagnosis context, a broad range of factors are screened for, including: substance-use, physical and psychosocial functioning and mental health. Screening tools frequently employed in the context of dual diagnosis include:

- Addiction Severity Index
- CAMH-CDS (Centre for Addictions and Mental Health Concurrent Disorders Screener)
- DAST-10 (Drug Abuse Screening Tool)
- AUDIT (Alcohol Use Disorders Identification Tool)
- DUDIT (Drug Use Disorders Identification Tool)

Mental health and substance-induced dual diagnosis

Substance toxicity and withdrawal can frequently mimic symptoms of mental ill health, which may create challenges for practitioners in distinguishing between substance-induced symptomology and a mental health condition(s), though a number of explanations exist for possible simultaneous inter-activities (Blanchard, 2000). Of note, when an individual presents to services with what may appear to be a variety of conditions, practitioners ought to beware

of the high probability of underlying factors including personality type, stressors, genetic disposition, childhood trauma and/or complex familial relationships (Schukit, 2006).

Bartu (2009) suggests that one mental health condition may impact on another within the same period of time, which may represent a consequence of physiological and possibly neurological effects directly from the substance use, whilst conversely, an individual's experience of mental health conditions may contribute to their chronic use of substances.

According to the National Institute of Drug Abuse (2008), practitioners thus have the objective to differentiate between 'independent', 'substance-induced' and 'mental illness - induced' conditions. The institute cite the differences as:

> *'Independent' conditions persist even when one is abstinent from substances for a prolonged period, or which may have emerged prior to the substance use condition. This is classified as the primary condition.*
>
> *Substance-induced' mental health conditions are those directly resulting from the use of substances and classified as secondary conditions.*
>
> *Mental illness induced' conditions suggest the onset of substance use disorder precipitated by the prevalence of mental illness with potential vulnerabilities associated with psychotropic interventions'* (p.146).

Related to mental illness induced conditions, Gibbins and Kipping (2006) provide an example of an individual's use of substances while experiencing a depressive period. The individual may use cocaine, alcohol and/or cannabis with the unconscious objective of feeling better or raising their mood. Codeine, heroin or a broad range of the benzodiazepine group of drugs may be preferred, with the aim of reducing feelings of anxiety or restlessness.

The prevalence of conditions including cannabinoid-induced psychoses and substance-induced and anxiety conditions may be regarded as factors leading to the existence of a dual diagnosis. Likewise, the following interactive conditions and factors may be encountered: cocaine-induced mental health conditions, hallucinogenic-induced states of psychosis, opiate withdrawal, depressive states and sleep disruption, and psychoactive substance-induced organic mental disorders (Watkins et al. 2001; Schukit, 2006; DeVido and Weiss, 2012).

Reviewing what the diagnostic and screening process constitutes, there appears to be flaw-lines between what is expected of a process and what it actually may involve. This particularly relates both directly to diagnosis and with psychotherapeutic considerations. As explored above, and considering how the principle diagnosis generally reflects the issue that precipitated the service-user coming to mental health services, Cooper (2005), Verhague (2002, 2014) and Vanheule (2017) contend that there are some implications and elaborations suggested in relation to this and other aspects of the diagnostic process:

1. What may be experienced as a transitional phenomenon for the individual becomes formalised as a structural element (Vanheule, 2017, pp.133-136).
2. The individual is frequently encountered under emergency conditions (acute admission) which take priority in terms of diagnosis. In these circumstances, diagnoses would be expected to err on the side of caution with a bias towards over- rather than under-diagnosing (Vanheule, pp.137-144).
3. Service-users can be in a particular state and circumstance at the time, experiencing loss or distancing of supports with an inability, through shock or trauma, to correct for disorientation and failures in articulation (Vanheule, pp.144-153).
4. There are often urgent practical matters to be considered beyond the purely formal scientific aspects of diagnosis, which may relate to benefits/resources to be made available to the individual, recommendations requiring some effective consensus. There are also potential institutional limitations and distortions (Cooper, 2005)
5. The formal scientific diagnosis is based on generalised reckonings (which change from one edition of the DSM to the next), whereas the practitioner must also pay attention to underlying individual factors (Vanheule, pp.7-11) which can tend to get side-lined, particularly in the passing on of diagnostic details from one practitioner to another (pp.52-67).
6. Further distortions can derive from the unease many service-users experience in regard to the screening process
7. The formal diagnosis is a separate matter from specific interpretations deriving from such, but the interpretations are commonly treated as if they enjoyed the same sort of scientific or evidence-based authority as the findings themselves. (Again, this is

particularly the case when such interpretations are communicated from one practitioner to another)

8. These difficulties prevail of course, largely because diagnoses tend to be made in near emergency circumstances and so involve a '*best guess*' which, though tentative, allows enough decisiveness to enable a coherent treatment plan to be put into operation. The problem is that due to the deliberate conservatism of science in general and the psychological categorising process in particular, once a formal diagnosis has been established, there is reluctance to alter it (Verhague, 2002, 2014).

The chicken and egg dilemma: a psychoanalytic perspective

Related to these intricacies, the European Monitoring Centre for Drugs and Drug Addiction wrote in its annual report, '*Existing research about the causal relationships between psychiatric and substance disorders is inconclusive. The symptoms of mental disorder and addiction problems interact and mutually influence each other*' (2004, p.94). This dilemma is often referred to as the 'chicken and egg' situation. However, according to a psychoanalytic perspective of Loose (2011), this is based on a false premise. To assume that truth can be reduced to a general cause and effect variable, he argues, is ridiculous. *'Implying that certain pathologies can lead to certain addictions and that certain addictions can cause certain pathologies seems a very simplistic notion considering the complexities of problematic substance use and psychopathology*' (p.12). Considering this directly in relation to the eight points highlighted above, the literature further illustrates this perspective:

(1) The transitional element is explored at various stages and over various sessions towards identifying which elements are typical of prior service-user reactions and which elements are novel and distinctive. An individual, for example, became depressed after being responsible for serious harm to someone he or she cared about and had found that he or she '*couldn't move forward*'. The service-user argued, seemingly reasonably, that this was impossible since it would involve some minimising of the intensity of the guilt felt which he/she would see as essentially an evasion and betrayal. Exploration revealed that the individual had felt similarly unable to move forward in the aftermath of other very different and less serious crises, and yet had not been affected so as to require intervention and be diagnosed as depressed. In consequence, the individual became aware that while the intense feeling of guilt

might indeed prove an enduring burden, moving forward was nevertheless altogether possible after all (Verhague, 2014)

(2) Psychotherapy is not conducted under emergency conditions unless the crisis can be immediately alleviated through therapeutic engagement (through identifying some past trauma which is being unconsciously revived in the individual and causing the present panic, and effectively steadying him/her through comprehensive exploration of such). For a service-user to be accepted for therapy, there need to be some systemic (HSE) and other basic (social) supports already in place, and he/she must be able to enjoy some capacity for relaxation and be able to articulate his or her essential concerns. While safety is a main priority, so is value (Wigman et al. 2013). The focus will not be on a minimal maintenance of well-being but on achieving the client's most ambitious aspirations while adequately safeguarding the individual through this process. Sometimes such safeguarding involves recognising in regard to certain service-users that they may on occasion or from time to time be unequal to sustaining the demands of therapy/treatment and need rather to intensify their commitment to accessing other dual diagnosis related services and support groups (Faber et al. 1996).

(3) Psychotherapy works to identify and remedy the difficulties that have instigated and may yet instigate crises. As suggested, at times of crisis, service-users tend not only to experience disorientation but to lose the capacity to correct such disorientation, often through shock which involves some repression in regard to an associated cause of the shock. Often also, individuals find it difficult to find words to speak, even to themselves, about issues associated with the shock or with the crisis or sexually or otherwise embarrassing issues, even when such associations have not been actually repressed. Through psychotherapy he/she becomes enabled to articulate and fully recover such blockages, allowing him or her to return to an appropriately instinctive and effective response to life's surprises and contingencies (Buchheim et al. 2013).

(4) Psychotherapy allows individuals to discuss in confidence contradictions arising between their pragmatic concerns and authentic self-expression. Service-users may represent their mental health and/or addiction issues as less severe than they are for legal or occupational purposes, or as more severe than they are to elicit sympathy or to retain benefits. Service-users, out of pragmatic concerns, may conceal or

misrepresent important details representing a suicide attempt as an accidental overdose or presenting with an anxiety attack without revealing associated substance abuse. Individuals have very commonly failed to confide important and often preoccupying aspects of their thought, imagination and feelings for fear that they might be considered insane. According to Karlsson (2011), often these various misrepresentations and concealments, continually repeated over time, have influenced the client's own self-perception, and psychotherapy can be highly effective in rectifying this. Some such declarations are not subject to confidentiality because they involve issues of serious risk or are subject to a previous client/therapist/referring agency, agreement. Care is taken to remind individuals regarding such potential limitations regarding confidentiality. Service-users attending support groups such as AA, GA, NA often find the disciplines, procedures and supportive social connections highly beneficial, while at the same time having misgivings about specific theories and/or practices associated with the model. Direct expression of such misgivings to other participants can be problematic as there are generally to a greater or lesser extent defensive elements involved. (A similar dynamic may apply regarding rejection of advice or criticism from family or significant others). Psychotherapy assists clients in separating these defensive elements from what may be genuine and important singularities of experience and differences of outlook (Wenzel et al. 2012).

(5) As indicated above, the institutional structures of the various services (the support groups as well as the addiction and mental health services) lead almost inevitably to a certain degree of generalisation in regard to service-users, as perhaps do psychological and sociological approaches by definition. The individual's issues or concerns, and in particular the issues precipitating diagnosis (p.36), tend to be viewed in terms of a general category applying to very different individuals with very different temperaments and life experiences. In psychotherapy, such issues and concerns are regarded rather as passages and punctuations within the individual's own autobiography, which helps identify far more clearly their individually specific and generally more essential and crucial meaning (Bieling et al. 2006).

(6) The unease created by the screening process can involve an evaluation largely based on normative assumptions, and can be regarded as just one of the inhibiting effects of

the client being under observation. In psychotherapy, the service-user as self is not under observation. It is his or her words that are observed, and while the talk within therapy is informal, it is formally evaluated by the therapist, and this formal evaluation is mirrored back to the individual who can consider it for verification by reference to the actual words (intended or not) that he or she has said (Faber et al. 1996).

(7) As suggested, the interpretations are not determined exclusively by the diagnosis. So while the individual may identify with suffering from depression, for example, or anxiety disorder or an addiction, his or her understanding of what this means may be very vague or confused. While the individual may have at various times or continually over time been anxious, depressed or indulged in excessive impulsive behaviour, usually not all such manifestations were significantly problematic. In therapy, there is an emphasis on establishing when such attributes caused serious difficulties for the individual beyond his or her control – in other words, there is an emphasis on identifying the particularities of the transitional crisis. This tends to involve events and subjective associations unique to the individual, and requires patient and sensitive exploration (Vanheule, 2017).

(8) The diagnostic categories in the DSM refer to public health expectations, expectations that can alter over time, but which tend to be changed gradually and often belatedly. They tend, therefore, to be treated over a significant course of time as being less tentative than they are acknowledged to be in actuality. Individual diagnoses are often highly tentative, and practitioners are ready to alter them appropriately. However, such moves towards change or modification depend on relevant feedback from the client, and often such feedback is not forthcoming. The service-user may identify strongly with the original diagnosis, or may habitually misrepresent his or her state of wellbeing, or may be apprehensive of complications or inhibited for various other reasons. Therapy commonly assists the service-user not only in gaining more insight into his/her condition but in more effectively articulating such (Borsboom et al. 2013; Vanheule, 2017).

The impact of drugs on the individual is what encouraged Freud to pursue and develop psychoanalysis, and his starting point for addiction was dual diagnosis (Loose, 2011), his first diagnostic distinction being between psychoneuroses (the neuro-psychoses of defence as he

termed them) and actual neuroses (Verhague and Vanheule, 2005). Having linked the actual neuroses to addiction, he subsequently stopped treating either, as he believed that both actual neurosis and addiction do not manifest analysable symptoms. In his early work on cocaine (conducted from 1884to 1887) he discovered that it did not affect everyone in the same way. He highlighted the fact that cocaine had an optimum effect when the user's psychological condition was depressed, and a lesser effect when cheerful (Freud, 1885, p.104). Following this, Freud concluded that the problematic effect of a drug on a user lay within the individual, and, having decided cocaine was not going to be useful pharmacologically, he focused on studying that variable within the individual, the constitution of the human psyche.

Naturally, alcohol and other drugs each have particular sets of generic effects, but to think that the same drug affects everyone in the same way is an incorrect assumption, yet it is one that is still maintained by many treatment responses, perhaps as a way of justifying research that focuses on the drug itself in order to avoid the complexities raised by its differing relationships with different individuals. Loose (2002) explores these complexities in more detail and introduces a mechanism which he calls '*administration*', which he believes contributes to a psychoanalytic understanding of how drugs affect people differently. One may ask, what has this got to do with dual diagnosis? Loose contends that in order for us to be able to understand the type of relationship the individual has with the drug or drugs that he or she '*administers*', we cannot respond in a way that truly focuses on the individual. In our collective response to dual diagnosis, we can only authentically respond if we can understand what the individual's experience is of what underlies that particular diagnosis (Schukit, 2006). The experience of working with dual diagnosis in the context of this inquiry suggests that each person's experience of such complexities is unique, underlining the need to continue to respond to the individual's particular psychical experience, as Freud suggested from what he discovered in his work with cocaine (Freud, 1913). Within the process of diagnosis, Berrios and Marakova (2006) suggest the following factors ought to be considered:

- *the intrinsic complexities of substance use, misuse, and dependence;*
- *the complexities surrounding the term 'mental illness', the many diagnoses of such, and the use of identical words to describe different things;*
- *methodological variance in studies conducted* (p.32).

Psychological and psycho-social factors relative to dual diagnosis

Blanchard (2000) highlights the considerable social, psychological, and physical consequences for those experiencing dual diagnosis. These complex factors appear to be more evident in individual's experiencing such conditions over the long term (RachBeisel et al. 1999; Blanchard, 2000; Castel et al. 2006). How psycho-social and psychological elements affect a client's engagement with treatment and the outcomes of the treatment have also been highlighted by Lehman et al. (1990), Hoff and Rosenheck, (1999), Grella and Gilmore, (2002), Hunter et al. (2005), and Lincoln et al. (2006).

Negative factors frequently emerge among those with lower levels of social functioning and who are experiencing social deprivation such as homelessness, inaccessibility to employment and education, poor levels of cognition and limited social skills (Lehman et al. 1989; Drake and Wallach, 2000; Johnson et al. 2002; Kirby and Keon, 2004; Castel et al. 2006). MacGabhann et al. (2004) also note the consequence of such psychological and social complexities on the individual's family (Barrowclough et al. 2001; Baker et al. 2012).

In a dual diagnosis group setting, Kavanagh et al. (2003) also explored how psychological and social capacities are affected by various levels of risk-taking, specifically physical self-harm. Leham et al. (1989), Weaver et al. (2003) and Gelkopf et al. (2006) also highlighted the risks surrounding suicidal ideation and intent. In relation to individuals within this client group engaging in physical violence with others and the consequential risks of imprisonment, the following studies highlight particular psychological and psycho-social consequences across a broad geographical and cultural range: Drake and Wallach, (2000), Banerjee et al. (2002), Johnson et al. (2002), Weaver et al. (2003) and MacGabhann et al. (2004).

Also, the following studies point out the significantly higher financial costs for providing care for individuals experiencing psychological, physical and social effects in the context of dual diagnosis: Burman et al. (2001), Weaver et al. (2003) and Hunter et al. (2005).

Evaluating how effectively dual diagnosis can be predicted, Marsden et al. (2000) give priority to factors such as physical health, levels of substance use, engagement with mental health services over time, and family/social relationships. Similar factors were cited in Johnson et al.'s (2002) study, which also cited not having a previous engagement with mental health

services as a factor in identifying dual diagnosis. Interviewing clients experiencing dual diagnosis, Castel et al. (2006) found that multiple conditions related to dual diagnosis, were especially linked to factors such as limited social support, being female, cannabis use, legal implications, and unemployment.

The literature shows a striking consistency in illustrating a connection between mental health factors and substance use. Equally striking, is the lack of consistency in terms of interpretation regarding, for example, causation orientation or even if association is causative. From the literature reviewed in this section, it is evident that many of the clinical and populations studies were conducted remotely (from patient case notes and/or statistics), or with the adoption of positivist approaches to data collection and analysis. Although people experiencing dual diagnosis were interviewed in varied studies, particular challenges emerge when methodological variance occurs across a range of different environmental contexts. In particular, many of the studies have been conducted '*on*' people in various institutions and mental health settings. In terms of working effectively with this complex group, such methodological approaches appear to have contributed little in terms of service development or provision. Although much of the literature concerning the psychological and psychosocial factors relating to dual diagnosis continues to inform what services we aim to provide today, what can equally be drawn from the literature is that there is little integrated approach to research or little experiential research conducted in this particular realm.

Dual diagnosis: cause and influence

Considerable argument permeates the literature concerning the initial emergence of dual diagnosis symptomology, the probability of mental conditions being induced by substance use, and where mental illness induces dual diagnosis (Kavanagh et al. 2003; Anderson, 2006 and Holt et al. 2007).

Both the National Institute on Drug Abuse (2008) and the Centre of Addiction and Mental Health (2006) suggest the following framework as a way of describing possible causes and influences contributing to dual diagnosis:

- *substance use provokes the onset of mental ill health;*
- *mental ill health may create the desire to self-medicate;*

- *both substance use and other mental health conditions are influenced by genetic and/or neurological factors notwithstanding historical trauma* (p.136).

Referring specifically to this framework, and aiming in addition to facilitate the diagnostic process among practitioners, Lehman et al. (1989) outlined the following criteria for the emergence of dual diagnosis:

- *the existence of a primary mental illness as a consequence of substance use;*
- *the existence of a primary substance use condition influenced by mental ill health;*
- *common causation* (p.24).

Exploring these criteria, the *primary mental illness theory* proposes that chronic substance use emerges as a self-medicating and/or coping process (Phillips and Johnson, 2010). This may indicate that the substance(s) chosen may be connected to underlying mental health conditions. Alternatively, the *primary substance theory* (Bickel and Marsch, 2001) suggests that substance use causes the mental health condition(s). All the studies agree that mental illness resulting from chronic substance use may continue even when the substance use discontinues.

The *dual diagnosis theory* suggests that two unrelated conditions can influence one another, and the literature reviewed in this context indicates that this category will almost always include those who experience psychosis (Lehman et al. 1989; Merikangas et al. 1994; Kirby and Keon, 2004). The *common causation theory* proposes that when an individual is vulnerable to dual diagnosis, psycho-social and physiological factors are frequently experienced (Kessler and Price, 1993; Cleary et al. 2008; Hunt et al. 2013).

Cost implications: mental health, dual diagnosis

Analysing societal costs in terms of consequences resulting from the broad realm of mental illness have been explored by O'Shea and Kennelly (2008) considering financial costs and by the MHC (Mental Health Commission, 2011) in the context of human costs, referring in particular to the recent economic recession. O'Shea and Kennelly (2008) suggest the cost of Ireland's mental health distress exceed €3 billion (equalling 2% of GNP), with most of these borne in the labour market, including unemployment, disability, premature retirement, premature death and incarceration. The cost implications for Ireland's health care system are

less than a quarter of the overall costs. The IMO (Irish Medical Organisation, 2013) states that next to the dominance of cardiovascular disease related costs, mental illness places particular pressure on Ireland's annual health budget. Alarmingly, Ireland's 2015 mental health budget expenditure has fallen by approximately 52% from 2008 to 2015.

Considering the diverse psychological, physical, and social factors which dual diagnosis presents, it seems that a strategic approach to service delivery may be more efficacious and offer more value. Although the literature undoubtedly highlights limited treatment outcomes for this population to date, their high level of risk in terms of severe mental ill health, social exclusion, poor psycho-social functioning, incarceration and premature death is also evident. Surely as service providers we have a responsibility to re-evaluate our response to dual diagnosis, as clearly there are no winners from the current reactive and uncoordinated response. The Government of Ireland's document *A Vision for Change* (2006) outlines planned changes for mental health, including recommendations for the delivery of clinical programmes for dual diagnosis, but these yet remain to be delivered (Irish Medical Organization, 2010; MacGabhann et al. 2010).

While some methodological variance and approaches have been adopted to inform conceptual models for dual diagnosis, considerable investigation has been applied in areas concerning prediction, cause and prevalence. The literature also suggests that disciplines and practitioners engaging with this population are at variance in terms of language and terminology employed. The efficacy of this must be questioned. For example, where it may be necessary and appropriate to continue to use the discourse relative to the discipline of psychiatry within the clinical area of mental health and mental health service development, the contemporary literature seems to suggest that psychiatry's discourse is rendered completely inappropriate and of no particular value or use when working with the dual diagnosed population in practice.

> *'Prevalence and incidence is not precise, as without a clear, consistent and accepted definition of dual diagnosis there are a variety of ways in which the phenomenon is observed and results reported'.*
>
> Hamilton (2014, p.34)

Dual diagnosis: global prevalence

This section will review literature referring to:

- early empirical studies identifying prevalence;
- international general population epidemiology studies ;
- international prevalence studies conducted with substance using populations over the past twenty five years, and prevalence rates in Ireland.

It will also explore the literature that refers to:

- the diversity of psychiatric comorbidity;
- the greater prevalence of psychiatric comorbidity among substance-use populations in comparison to the general population;
- the impact of the increased ability to identify co-occurring psychiatric disorders through the development of diagnostic criteria and standardised assessment tools.

The following factors ought to be considered when exploring this section in the context of potential impact on research validity and on the comparative ability with which to compare prevalence studies:

- methodological applications adopted;
- assessment and diagnostic procedures adopted;
- definitions used;
- the particular context of the study;
- substance use trends;
- duration of and types of substance used;
- attitudinal/cultural variance relative to substance use.

(Weiss et al. 1992; Watkins et al. 2001; Kavanagh et al. 2003; Rush et al. 2008; Baldacchino and Crome, 2011).

Prevalence studies: 1970s – 1980s

Studies in this period brought the concept of dual diagnosis into the public domain, giving rise to further empirical investigations into the prevalence of depression and other psychopathology in substance misuse. Early studies, however, also showed a significant variance in the prevalence of dual diagnosis because of a disparity in the diagnostic tools and classification systems adopted. As well, most early studies concentrated on clinical samples and also focused on the severe end of the dual diagnosis spectrum, which gave a rather limited picture of the actual prevalence of dual diagnosis.

In the mid-1970s the realisation that people who were using substances were also experiencing depression began to appear in the literature. For example, using a standard rating scale tool for depression, Weissman et al. (1976) found 33% of a sample of opiate users in treatment were moderately depressed; while within a mixed sample of heroin and alcohol dependent clients were experiencing a dual diagnosis of chronic depression (Weissmann et al. 1977). In the same period, Mintz et al. (1979) reported dual diagnosis rates in US soldiers returning from Vietnam. The impact on public services resulting from this stimulated further studies concerning dual diagnosis with this veteran population. Findings from this group included: self-medication, anxiety disorders and poly-drug use (Woody and Blaine, 1979; Croughan et al. 1981; Maddux et al. 1987).

In a mixed methods study of heroin dependent individuals in treatment, Rounsaville et al. (1982) using a structured interview survey to measure current and lifetime rates of dual diagnosis and found the majority of the group sampled met criteria for at least one other mental health condition with substance dependency. Schizophrenia and mania rates were low in this sample and similar to those reported in the general population. Depression symptoms in opiate-dependent individuals in treatment were explored by Rounsaville et al. (1982), who measured individuals' levels of depression on treatment engagement and six months after. It was found that 17% were currently depressed and 60% had increased depressive symptoms. This study suggested that engagement with treatment impacted positively on symptoms, but individuals who were depressed on entering treatment demonstrated poorer outcomes in subsequent drug use and mental health effects.

Employing the DSM-III criteria and the 'National Institute of Mental Health Diagnostic Interview Schedule' to measure lifetime prevalence rates, Michie et al. (1985) conducted a study of a hospitalised group of alcohol-dependent individuals. Variance examples were identified in diagnoses according to gender, including anti–social, personality and substance use conditions linked with males, while chronic depression and phobic symptoms were reported by females.

Accessing data from a National Epidemiology study (Epidemiology Catchment Area Survey, ECAS, in the United States, Helzer and Pryzbeck (1988) looked at the relationship between alcohol dependence and other mental health conditions in the general population. Specifically, the study focused on potential sampling bias which may affect the specificity of prevalence figures, and where an individual with more than one diagnosis may access treatment more quickly than someone with one diagnosis. The main finding in this research was the greater occurrence of dual diagnosis in people with alcohol dependence, compared to participants who were not dependent. Similar to the findings of Michie et al. (1985), this study identified a particular link between alcohol dependence, other substance use, anti-social personality conditions and mania.

Employing the National Institute of Mental Health Diagnostic Interview Schedule and DSM-III diagnostic framework, Ross et al. (1988) explored the lifetime and current prevalence rates of mental health conditions in a sample of individuals seeking treatment for alcohol and substance dependence. The findings showed 78% of participants met criteria for a lifetime mental health condition and substance use, while 65% had one current mental health condition. Individuals dependent on stimulants, benzodiazepines and alcohol were more at risk for dual diagnosis. More dominant lifetime conditions included: anti-social personality conditions, major depression and phobias.

Reviewing the literature on the prevalence of dual diagnosis internationally, particular challenges emerge concerning the equally broad adoption of multiple methodological approaches in these studies and reports. Because of the complexities concerned with such methodological variance, it is understandable how this lack of uniformity remains in the literature. Such a methodological disparity, of course, may equally permeate current clinical and population studies. With the emergence of more participatory-methodological approaches to health care activities in general, and specifically concerning dual diagnosis, these

collaborative approaches help better understand the appropriate methods of measuring prevalence. In other words, measuring prevalence may be very beneficial if there are appropriate methodologies employed that blend well with effective responses/interventions to support such approaches. Where methodological variance exists, the lack of consensus is an inevitable outcome and one which subsequently influences approaches to and decisions concerning service development.

International epidemiology studies

A major US epidemiology survey in the early1980s, the National Institute of Mental Health Epidemiologic Catchment Area (Reiger et al. 1990), provided the basis for further empirical understanding of lifetime rates of dual diagnosis and influenced the undertaking of similar epidemiology studies throughout the world. According to Reiger et al. (1990), the national ECA study measured dual diagnosis prevalence in a sample of 20,000 adults over four years. The findings showed that the lifetime prevalence of dual diagnosis was 22% for non-substance mental disorder, 14% for alcohol dependence and 6% for other substance use disorders. Increased levels of dual diagnosis (52%) were found in the sample among those whose dependency was other than alcohol, while dual diagnosis with alcohol dependence was 37%.

In 1990-1992, The National Comorbidity Study (NCS) in the US was the next large-scale survey to explore levels of current and lifetime dual diagnosis between substance use and non-substance use 'disorders' in the general population. It was found that lifetime dual diagnosis rates were similar to those found in the ECA study. The prevalence of any current diagnosis was 30%, and of that group 20% had at least one other substance use disorder (Kessler et al. 1994, 1996).

The National Comorbidity Survey in the US surveyed households for current prevalence rates for anxiety, mood and substance use disorders using the DSM-IV diagnostic criteria. Findings included: 18% for anxiety and substance use, 10% for mood and substance use; 23% were listed as serious, 38% as moderate and 41% as mild. The figures from the former survey were higher and may represent developments in the methodological tool employed, i.e. the CIDI (Composite International Diagnostic Interview); (Kessler et al. 1996).

Findings from the large-scale Ontario Health Survey (Ross, 1995), a national household survey in Canada, included: 55% of individuals with an alcohol disorder had a lifetime dual diagnosis, and there were higher rates of dual diagnosis in females with alcohol dependency. Exploring dual diagnosis prevalence over a six-month period, Kessler (1995) found that data from the ECA and NCS studies were similar to that of the Canadian study.

In Britain, national epidemiological studies, including the 'National Psychiatric Morbidity Survey' (1997), accrued data suggesting particular links between mental ill health and substance use. Meltzer (1997) reported findings which suggested that 12% of males and 4% of females had a drug dependency along with a mental health diagnosis.

In Holland, the general population *Mental Health Survey and Incidence Study* (NEMESIS), found that 45% of participants who met criteria for one mental health disorder also had been diagnosed with one or more disorders. Further, 40% of males and 15% of females with mood disorders also met criteria for substance dependency (Bijl et al. 1998).

The National Mental Health and Well-Being Epidemiological Survey (1998) in Australia established dual diagnosis prevalence findings in the general population, showing that 18% met DSM-IV criteria for current psychiatric disorder and substance dependence. This is lower than that of the NCS, and may be attributable to variance in the DSM criteria adopted. This survey found that a quarter of respondents who met criteria for anxiety, affective or substance dependency disorders also met criteria for one or more other psychiatric disorders.

Prevalence in clinical samples from 1990 to date

In the 1990s the introduction of the DSM-III and the ICD-9 standardised classification facilitated the regularity of epidemiological studies on the prevalence of dual diagnosis, though also supporting the development of assessment and diagnostic tools for the identification of mental ill health and dual diagnosis. With a view to improve understanding of dual diagnosis prevalence, empirical studies from this time to date generally employed structured interviews and standardised screening tools across both general population and clinical samples.

In the western world, Kelzer (1996) estimated from a review of empirical findings that up to 50% of the general population at some point in their life experience dual diagnosis. Lurigio and Swartz (2000) further suggest that up to 75% of people in addiction treatment were dual

diagnosed, while Rachbeisel et al. (1999) found between 20% and 50% of people in acute mental health services had a dual diagnosis. However, the clear representation of such prevalence seems to be complicated by methodological variance inconsistencies, the breadth of mental health and substance use conditions explored and diagnosed, and discrepancies in population samples across a broad range of mental health and addiction treatment services (Weiss et al. 1992; Wittchen, 1996; Rush et al. 2008; Baldacchino and Crome, 2011).

The United States and Canada

In an outpatient addiction treatment centre in the United States, Watkins et al. (2004) interviewed service users presenting with criteria of substance dependence and another mental health condition, the aim of the study being to determine dual diagnosis prevalence. The findings concluded that 50% of the sample met criteria for dual diagnosis, while 33% of the sample met criteria for two or more mental health disorders. The predominant conditions with substance dependence included depression (54%) and anxiety disorder (40%).

In a similar study, Johnson et al. (2002) found 45% of the sample met criteria for dual diagnosis, though with higher rates of depression, psychosis, anxiety and impulsive behaviour. In this study, prevalence rates equalled a similar study of heroin addicts in treatment, where 47% of the sample were dual diagnosed (Brooner et al. 1997). Findings included predominant rates for anti-social personality disorder (25%), chronic depression (16%), while 96% met criteria for substance dependence linked with more than one substance. In an alcohol detox programme, Johnson et al. (2007) found 80% of the sample met criteria for dual diagnosis.

These studies adopted symptom questionnaires which were self-reporting; hence prevalence of dual diagnosis was not diagnosed by the practitioners.

A Canadian study of active heroin users measured depression rates and found 50% of the sample met the CIDI criteria, which is similar to dual diagnosis prevalence rates in treatment settings (Wild et al. 2005).

Australia and New Zealand

The prevalence of dual diagnosis among heroin dependent people in treatment setting samples in Australia was found to be high. In comparison to the general population, Ward et al. (1998) found lifetime rates for this outpatient group included depression (30%), anxiety (8%), phobias (40%), and antisocial personality disorder (42%). Of a sample measured in a

residential addiction treatment setting, Dingle and King (2009) found 92% met criteria for dual diagnosis. Predominant rates included 57% for chronic depression, 20% for anxiety, and 16% for borderline personality conditions. These rates may differ from other studies because the setting was a private service which had greater access to resources and varying profiles of psycho-social factors for the clients involved.

Another Australian study measured prevalence among heroin-dependent individuals one year before starting treatment and when entering outpatient treatment. Callaly et al. (2008) found that one year before treatment 75% met criteria for dual diagnosis, 66% met criteria for anxiety, and 50% met criteria more than one mental disorder with substance dependence. On entering treatment, criteria for dual diagnosis was met by 70% of the male group and 90% of the female group.

Consistent with the previous study, a sample of people attending an outpatient addiction treatment centre in New Zealand and who participated in a dual diagnosis prevalence study conducted by Adamson et al. (2006), showed 74% for lifetime rates for dual diagnosis. Other predominant rates included 31% for chronic depression, 32% for phobia, and 30% for post-traumatic stress disorder. Again in New Zealand, in a prison population where dual diagnosis prevalence was measured, Simpson et al. (1999) found dual diagnosis predominantly in people also diagnosed with obsessive compulsive disorder (96%), bi-polar disorder (92%), schizophrenia (85%) and depression (88%). These rates were found to be consistent with international comparison studies of prison populations.

Assessment, diagnostic processes and treatment implications

This section looks at the implications of dual diagnosis for assessment, diagnostic processes, and treatment. In particular, it looks at:

- the different assessment and diagnostic procedures adopted;
- the management of dual diagnosis;
- potential barriers to treatment;
- the assessment and treatment of dual diagnosis in Ireland.

Assessment and diagnostic matters

The importance of evidence-based practice has been highlighted in the literature relating to dual diagnosis assessment (Lehman et al. 1990; Wittchen, 1996; Drake et al. 2001; Teeson and Proudfoot, 2003; Wu et al. 2003; Swartz and Lurigio, 2006). The evidence suggests that standardised assessment tools establish three times more diagnoses than clinical assessment (Basco et al. 2000; Baldacchino and Crome, 2004), and that the most frequently reported diagnoses are depression, anxiety, anti-social personality disorder, and post traumatic stress disorder (Darke et al. 1992; Merikangas et al. 1996; Skinstead and Swain, 2001; Teeson and Proudfoot, 2003; Watkins et al. 2004; Centre for Substance Abuse Treatment, 2005; Castel et al. 2006; Holt et al. 2007; National Institute on Drug Abuse, 2008).

The 1989 paper by Lehman et al., which specifically referred to integrated assessment and classification criteria for individuals experiencing dual diagnosis, was influential in terms of policy development. The prevalence of dual diagnosis and the need for practitioners to recognise it in the assessment process was highlighted in this paper. Following on from this, and in order to understand how one condition influences another, Sacks (2008) recommended the integrated approach to assessment, which facilitates communication between practitioner and client. This approach, the authors claim, allows the inter-relationship between substance-use and mental health disorders to be better understood.

Regarding policy development and service provision, McGovern et al. (2006) suggested that those planning to provide services for dual diagnosis should take into account: (a) dual diagnosis prevalence; (b) current practices; (c) barriers to treatment; and (d) cultural attitudes. This review, however, also highlighted the fact that that there was a deficit in both mental health and addictive services internationally in terms of reflective-oriented practice.

In relation to the assessment process, there are particular considerations to be clarified, according to Weiss et al. (1992), the National Institute on Drug Abuse (2008) and Flynn and Brown (2008). These include the length of time for which an individual is drug or alcohol-free before assessment and the continuing assessment of substance use and/or mental ill health symptomology.

Different substances produce different effects on different people at different times, as seen in the links between heroin use and depression, and for this reason Castel et al. (2006) suggest that any ongoing assessment process should consider these inter-connections over time. In this

regard, where poly-drug use is prevalent, the assessment process may be complicated further (Eland-Goosensen et al. 1997; Strain, 2002). Recommendations by these studies include the necessity for addiction and mental health services to measure for multiple conditions in order to increase the efficacy of the treatment.

According to Sacks (2008), the assessment process includes collating client data through various standardised tools, structured interviews focused on psychosocial, mental health, and substance-use histories. Kavanagh et al. (2003) also contend that an individual's insight into their substance use, their motivation to change, and the impact on their mental health ought to be measured, as these may relate to the potential treatment plan.

Adopting standardised assessment tools can be effective both in collating pertinent client data and as an objective way of establishing rapport (Banjeree et al. 2002; Teeson and Proudfoot, 2003; Sacks, 2008). Mueser et al. (2003) recommend that assessment should be engaged with over the longer term.

Mental health related questionnaires

Using questionnaires in mental health and addiction treatment has provided practitioners the means to collect precise data. For example, the GHQ (General Health Questionnaire), the BAI (Becks Anxiety Inventory), the BDI (Becks Depression Inventory), and the SCL-90 (Symptom Checklist) are effective tools for gathering information critical for assessment and treatment and which may help identify areas of concern warranting further investigation. Strain (2002), however, notes that there are inherent limitations to questionnaires, checklists, and self-reporting measures as they are merely one minor intervention in the long-term assessment process.

Clinical assessment, structured diagnostic interview

A primary assessment tool for practitioners has been the Structured Clinical Interview for DSM Disorders (SCID). Shear et al. (2000), however, found that mood and anxiety disorders were under-diagnosed by practitioners' interpretations of the SCID. In order to provide a comprehensive assessment of the service user, Sacks (2008) strongly recommended establishing a balance between appropriate assessment tools, clinical assessment measures, and both formal and informal interviews.

The SCID and the Composite International Diagnostic Interview (CIDI) when used in reference to diagnostic criteria contained in the DSM and ICD provide increased accuracy to the assessment process (Dawe et al. 2002; Zimmerman, 2003; Centre Addiction Mental Health, 2006; McGovern et al. 2006; Flynn and Brown, 2008).

Mental health conditions that are a result of substance use or which remain after use has finished can only be determined by an assessment process that take place over time (Akker et al. 1996). Clinical assessments of mental health include the evaluation of cognitive functioning such as attention, memory, concentration, perception, and thinking. Because similar aspects are evaluated in the addiction services, it is important to consider symptoms of mental ill-health and how these may relate to the person's current drug use or not, since substance-induced symptoms will inevitably change over time (Weiss et al. 1992; Flynn and Brown, 2008; National Institute on Drug Abuse, 2008). In this regard, the timing of the assessment is important for specifying between substance-induced or mental ill health induced dual diagnosis, where symptoms of substance withdrawal can mimic those of mental disorders. Risk factors must be also considered, both in the assessment process and when referring to appropriate services, especially when evaluating susceptibility to psychosis and/or self-harm.

Service provision

According to Drake et al. (2007, 2008), and SAMHSA (2013, 2014), in order to respond effectively to dual diagnosis, service provision ought to include psychosocial and pharmacological interventions in the majority of settings. The management of severe mental illness requires pharmacological support (Ziedonis et al. 2005; Ministry of Health, 2010), which is ideally bridged with psychosocial interventions (Mueser et al. 2003; Hunt et al. 2013). The amalgamation of these psychosocial and pharmacological interventions are generally delivered through the following three approaches to service provision:

- *The serial approach* responds to all disorders simultaneously, though by varying service providers (DeVido and Weiss, 2012). As the individual accesses service providers in different locations, the challenges of this approach include the inability to monitor how one disorder can influence another disorder, which can negatively impact on the functionality of the individual (Jacobs et al. 2005; Phillips, 2010).

- *The parallel approach* includes the management of mental health and substance use conditions by varying practitioners in multiple agencies, though with planned coordination between the various agencies central to this approach. The challenge in implementing this approach has been to maintain collaboration successfully between separate services (DeVido and Weiss, 2012).
- The proposed effective response to dual diagnosis is *the integrated approach* (Farren et al. 2012). While no particular model for integrated service provision exists, it can be broadly defined as having a range of pharmacological and psychosocial interventions available to the individual provided by the same agency (Ziedonis et al. 2005; Todd, 2010; DeVido and Weiss, 2012).

The literature indicates that the integrated approach is the most likely effective holistic approach to service provision for dual diagnosis (Rush et al. 2005; CSAT, 2007a, 2007b, 2007e; Todd, 2010; NCCMH, 2011; Baker et al. 2012; Hunt et al. 2013), especially those that include psychotherapeutic interventions such as Motivational Interviewing (MI), Cognitive Behavioural Therapy (CBT), Acceptance Commitment Therapy (ACT) and Dialectical Behavioural Therapy (DBT). Integrated dual diagnosis service provision is based on the premise that the same team of practitioners engages with the service-user whilst addressing both mental health and addiction concerns (McGovern et al. 2006; Lundgren et al. 2014; Connolly et al. 2015).

Irish policy development

In 2006 in Ireland, the Department of Health and Children published the report of the Expert Group on Mental Health Policy entitled *A Vision for Change*, which set out a number of recommendations in relation to dual diagnosis.

- *Recommendation 15. 3. 1: Mental health services for both adults and children are responsible for providing a mental health service only to those individuals who have co-morbid substance abuse and mental health problems.*
- *Recommendation 15. 3. 2: General Adult CMHT's (Community Mental health Teams) should generally cater for adults who meet these criteria, particularly when the primary problem is a mental health problem*. (EGMHP, 2006, p.149).

In addition to the management of service-users, two further recommendations on the development of specialist substance abuse mental health teams were included:

- *Recommendation 15. 3. 4: Specialist adult teams should be developed in each catchment area of 300.000 to manage complex, severe substance abuse and mental disorders.*
- *Recommendation 15. 3. 5: These specialist teams should establish clear linkages with local community mental health services and clarify pathways in and out of their services to service-users and referring adult CMHT's*. (p.149).

Following this, the *Transformation Programme 2007-2010* (Health Service Executive, 2006) stated that the reformation of national services should include:

- *the collaboration of the mental health services with primary care addiction services;*
- *engagement of staff in facilitating these changes and service developments;*
- *reconfiguration and relocation of staff and resources to community settings* (p.112).

From the addiction arena, *The National Drugs Strategy* (Government of Ireland, 2009) likewise proposed similar objectives, including the:

- *delivery of comprehensive treatments through multidisciplinary teams;*
- *integration of psychiatric and psychosocial interventions for concurrent disorders;*
- *development of these services in primary care settings* (p.74).

Building on the above policy publications, *The HSE National Service Plan 2016* highlights:

'Programme for Government 2016 funding priorities:

- *Continued investment in clinical programmes, including the development of two new clinical programmes, specifically Attention Deficit Hyperactivity Disorder (ADHD) in adults and children and dual diagnosis of mental health and substance misuse'* (Government of Ireland, 2015, pp.68-69).

Over the ten years since the publication of *A Vision for Change*, its recommendations have had challenges with implementation (Health Service Executive, 2010; MacGabhann et al. 2010; The College of Psychiatry of Ireland, 2012). However, in relation to the *HSE's National Service Plan 2016* (Government of Ireland, 2015), the indication that investment in clinical programmes for dual diagnosis is an optimistic development.

However, to date, there are no national guidelines on providing services for dual diagnosis in Ireland.

Organisational change and development

In reviewing the literature on organisational change and development, it appears that the manner in which organisational change happens may depend on the particular approach adopted (Cameron and Green, 2007). From this, the approaches developed by some of the key authors in the field of organisational change are introduced here.

In his formulation of field theory, Lewin (1951) claims that his action research approach to organisational change and development demonstrates that organisational behaviour varies over time and is influenced by the diverse environmental context in which it is located (Bradbury et al. 2008, p.78). Cameron and Green (2007) posit that Lewin's force-field analysis ideas provide a useful tool for considering organisational change. In this, Lewin suggested a three-step process. The first step includes 'unfreezing' the status quo, by stating the current state of the organisation, identifying the motivational and resistant factors and also identifying the desired state. The next step concerns working towards the desired state through active involvement and participation. The third state involves 'refreezing' and embedding the new state by establishing policy and new standards of operation.

> '*The force-field analysis can be an effective tool in facilitating organisational change, enabling teams to define the next steps and move quickly through the planned change process*' (p.98).

Drawing from the discipline of project management, Bullock and Batten's (1985) approach to planned change implies that organisational change is more of a technical problem, requiring a defined solution to remedy the problem. There are a number of phases. *Exploration* clarifies the need for change and the acquisition of required resources for the change to proceed. *Planning* involves key stakeholders in deciding what action plans are relevant. *Actions* are implemented according to cited plans with strategies for re-focusing built-in along the change process to bring plans back on track if necessary. Once action plans are implemented, the final *Integration* phase aligns the change with other aspects of the organisation (pp.383-394).

Kotter's (1995, 1996) eight-step model emerged from his analysis of over 100 various organisations undergoing change. This approach addresses issues of power positions in influencing the change process, while also signifying the importance of effective communication throughout the process. The actions required include:

- *Establish a sense of urgency.*
- *Form a powerful guiding coalition.*
- *Create a vision.*
- *Communicate the vision.*
- *Empower others to act on the vision.*
- *Plan for and create long-term wins.*
- *Consolidate improvements and produce still more change.*
- *Institutionalise new approaches.*

  Kotter (1995, p.62)

This eight-step model emphasises a cyclical approach, where importance is highlighted in keeping management involved in all phases throughout the change process (p.65).

Beckhard and Harris (1997) developed a change formula that can be brought into an organisational change process that identifies the elements that ought to be in place in order for change to happen. The formula is as follows:

C = (ABD) > X

C = Change

A = Level of dissatisfaction

B = Desirability of the proposed change

D = Practicality of the change (minimal risk and disruption)

X = 'Cost' of changing

According to Beckhard and Harris (1987), factors A, B and D must outweigh the perceived costs (X) in order to enable the change. If an individual or group whose participation is required does not require the change sufficiently (A), is not motivated enough to see the

change process through (B), and is not convinced of the need for the change (D), then the cost (X) of the change is prohibitively high, and that individual/group will resists the change.

While Beckhard and Harris indicate that resistance to change is to be expected, they also contend that leaders of change need to identify the particular forms of resistance, and in the process of reducing it, re-gain commitment to change from the individual/group.

The congruence approach developed by Nadler and Tushman (1997) views the organisation as a system that draws on internal/external resources, transforming 'inputs' (objectives, environment, resources) into 'outputs' (actions, behaviour, performance levels), in the process of transformation that identifies specifically what needs to happen to orchestrate the change. This model emphasises the assumption that everything is inter-connected, that varying elements of the system have to be aligned in order to acquire high performance levels of the entire system. In this, the following four 'sub-systems' make up the organisation, all of which are inter-dependent on each other.

- the work (day to day activities conducted by people);
- the people (skills and characteristics of employees);
- the formal organisation (organisational structure, system and policies);
- the informal organisation (power, influence and values).

Cameron and Green (1997), indicate that while this model provides a helpful checklist for those involved in bringing about change, this approach is 'problem-focused' as opposed to 'solution-focused', with little reference to strategy-building or goal-setting.

Methodologies

Reviewing the literature has illustrated vast methodological variance in approaches employed across many clinical and population studies internationally. With such methodological differences evident, particular challenges emerge in terms of application from one context to another. Furthermore, the varied methodological approaches adopted to research the broader and also the more particular areas of dual diagnosis have largely been heavily influenced by those working in psychiatry, psychology and in the mental health and addiction services. The predominant application of largely positivistic methodological approaches to how dual diagnosis has been researched may have helped create the distinct distance between the researcher and the researched. Perhaps this disparity, which permeates the literature, alludes

to some rationale why the development of effective and sustainable dual diagnosis services has been the exception rather than a positive outcome from the research conducted to date internationally, and particularly so in Ireland.

What is emphasised particularly is the varied differences in methodologies employed, which undoubtedly have contributed to the widely acknowledged lack of consensus concerning dual diagnosis in general, and in particular areas, including definition, sampling, symptomology, assessment, service provision and treatment. The great bulk of the literature reviewed has indicated that these studies and reports were conducted 'on' or 'about' people, employing methodologies and instruments aligned with a paradigm which distances the researcher from the researched. The probability of change in this context may be provided by participatory approaches to all areas concerning dual diagnosis, where the researcher and the researched inquire together, where professionals and service-users work together in shaping services which are developed and change over time in accordance to what is needed.

From the particular contexts within which the bulk of the research on dual diagnosis has taken place, the review also uncovered the dominant use of language that was quite repetitive and overwhelmingly jargonised (psychiatric/medical) across the literature. As a researcher encountering this predominant discourse in the literature surrounding this particular arena of human suffering, one has to consider what the distressed service-user must feel when confronted with such while trying to answer questions constructed from within medicalised or associated discourses. The administering of medication and simultaneous application of at least one diagnosis potentially further exacerbates this series of linguistic and communicative complexities.

In order to address these collective deficits in the realm of dual diagnosis in general, and in particular concerning the development of appropriate services for those experiencing dual diagnosis, it is therefore useful to posit a methodological approach that enables all stakeholders to co-participate in the generation of this knowledge. In this, participatory action research (PAR) has been selected to help bridge this gap in this particular context.

CHAPTER THREE: METHODOLOGY

Introduction

In order to respond comprehensively to the aim and objectives of this inquiry, a participatory action research (PAR) approach was selected. It may be appropriate to reiterate the aim and objectives of this inquiry here:

Aim:

The overall aim of the inquiry is to develop a comprehensive, integrated and contemporary recovery-oriented model of care for dual diagnosis within the environment of primary and continuing care in Cork, Ireland.

Objectives:

- to engage stakeholders in PAR's methodological framework in order to facilitate a clear pathway to services;
- to engage stakeholders in a critical reflective process seeking to collectively understand existing and emerging concepts and beliefs relative to dual diagnosis and related service transformations;
- to enact pragmatic developments in service delivery (through PAR) that demonstrate positive outcomes for clients (stakeholders) and families experiencing dual diagnosis;
- to contribute to learning, knowledge development and new ways of knowing for stakeholders concerned with dual diagnosis.

PAR's choice was inspired by three central factors:

(a) the overall aim of the inquiry;

(b) the environmental and cultural context in which the objectives for the inquiry were planned;

(c) the positioning of the lead researcher within the health care system.

Participatory Action Research (PAR) is part of the evolution of Action Research (AR) and has been influenced by many theoretical perspectives. In order to understand the evolution of

these participatory approaches, the broader theoretical and philosophical perspectives of research are initially explored. Action Research is thereafter discussed, followed by illustrations of PAR's suitability to this particular context.

Central to the research process of any inquiry is the selection of a research paradigm that will help apply the most appropriate method to fit the particular objectives of the inquiry. Exploring qualitative and quantitative distinctions and options, Silverman (2010) notes that '*methods are only more or less appropriate to particular research questions'* (p.9), suggesting that no one paradigm alone has been determined for deciding what does or does not constitute valid, useful and meaningful knowledge. In order to achieve a particular research objective, the methodology must be clearly identified, and the researchers must maintain congruency to that methodology.

Researchers should illustrate the philosophical approaches adopted in acquiring new knowledge and/or new ways of knowing, according to James and Vinnicombe (2002), suggesting that the researchers' innate sociological persuasion or '*philosophical stance*' may shape the direction of an inquiry. Blaikie (2010) further emphasizes the importance of coordinating such personal and philosophical choices with the inquiry topic to ensure and maintain consistency and coherency. Essentially, both authors agree that one's '*philosophical stance*' should allow the researcher(s) to compliment or align the philosophical approach, the methodology and the topic of inquiry. In the context of this inquiry, multiple realities or differing ontologies exist in and between the Mental Health services, the Addiction services, the researchers' practice ontology and the lived experience of the service providers and service-users.

Mills (1959) discusses in his text '*The Sociological Imagination*' the nature of reality and how we come to know about or inquire about that reality. In order to understand the underlying principles being adopted or one's epistemological understanding, and assuming that multiple perspectives of reality exist, it is necessary for the researchers to elucidate the perspective from which each view reality (pp.6-7). Essentially, two perspectives exist, specific reality and interpretive reality, so from a clinician's point of view, for example, the philosophical perspective of the nature of existence might not be answered; therefore what is key (for participants/stakeholders as in this PAR inquiry) is how clients and practitioners interpret and construct reality. Particular methods of inquiry have particular validity in clinical practice,

including the lived experience, phenomenology, ethnography and action research. Adopting a particular perspective, the methodological framework for this inquiry, Participatory Action Research (PAR), '*is about the many ways in which social science researchers can use action research methodology to overcome the limitations of traditional methodologies'* while aiming to gain a particular understanding of the participants' reality (Somekh, 2006, p.1). This specifically aims to link either theory practice or reality to experience, being the ultimate purpose of the research. The terms paradigm or worldview I use here interchangeably to describe my view about a general orientation about the world and the nature of research that researchers hold. My own worldview has been shaped by my life experience to date, the discipline I've worked in for the past twenty years, the beliefs of mentors and supervisors and previous research interests and experiences. These life processes, and particularly my experience of engagement with others during life's journey, have led to my embracing the worldview of participatory action research (PAR) for this inquiry.

The general philosophical debate in research primarily evolves within or from ontological and epistemological perspectives; aiming to answer questions including, what is reality? and how can we know what we know about this reality? Ontology, asserts Crotty (1998), is concerned with the nature of social phenomena and the beliefs that researchers have about the nature of social reality, in particular it refers to the *'what is'*, the nature of existence or being and the structure of reality. The researcher's view of reality according to Burnell and Morgan (1979) is fundamentally prior to all other subsequent assumptions, given that what is assumed at this level establishes or forms a basis or worldview for the researcher's other assumptions. Blaikie (1993) defines ontology for the social sciences as *'the science or study of being'* to incorporate *'claims about what exists, what it looks like, what units make it up and how these units interact with each other'* (p.6). Essentially, the concept of ontology describes the individuals view or belief about reality. Asking the questions: is our view a single reality (objectivist-external), or is it that there's no single but multiple realities (interpretivist-subjective)? As one's ontological position is one's personal worldview, reflecting one's understanding of self, one's perspective of the nature of the world and the nature of knowledge cannot therefore be refuted; as Guba and Lincoln (1990) posit, '*there can be no wrong or right ontology'* (p.146).

The term *epistemology* originating from the Greek word *episteme* (knowledge) refers to the most appropriate ways of inquiring into the nature of the world, looking at the possible origins

and nature of and limits to human knowledge. It also refers to the way humans create knowledge about the social world, concentrating on the reasoning behind our ability to acquire knowledge. Although a variety of epistemological positions inform the theoretical perspective, epistemology, according to Crotty (1998), attempts to explain '*how we know what we know*' and aims to establish the significance of the understandings we then reach. Essentially there are the two polarized epistemological positions: positivism and interpretivism. Positivism incorporates the use of scientific methodologies (quantitative) to gain knowledge and sits within the realist ontology (objectivist-external), using the testing of hypotheses (empiricist) as the theory for gaining knowledge (data). Interpretivism, in contrast, sits within the constructionist ontology considering knowledge as something that is created through interpreting or constructing the social world (Guba and Lincoln, 1994).

Navigating through examples of research paradigms led me to understand how different research paradigms within which action research can be undertaken would create different forms of knowledge. Given that the collective aim of this inquiry is to collaboratively develop a service which incorporates two worldviews (mental health and addiction), as lead researcher I believe that the inquiry's objectives can be best met by being grounded both in the interpretive and critical research paradigms.

Theoretical and philosophical paradigms

There are three worldviews that guide research in the social sciences, according to Willis (2007), each of which may vary regarding the nature of reality: positivism, post-positivism and critical theory, each of which guide us to different types of data and methods that provide valid, useful and meaningful knowledge. Each paradigm has different approaches to acquiring meaning from data collected and also may differ in terms of the connection between the research and environment in which it is taking place. Willis (2007) further notes that no consensus exists on whether one paradigm is better than another; rather, most approaches will likely contain certain '*flaws and weaknesses'* (p.21). Aliyi et al. (2014) critically examined the positivist and non-positivist paradigms, finding inherent conflicting approaches to research, and highlighted the necessity for a researcher to evaluate each approach prior to their employment in research projects in the social sciences (pp.79-91).

A paradigm as defined by Guba and Lincoln (1994) is '*a basic belief system or world view that guides the investigator, not only in choices of method but in ontologically and epistemologically fundamental ways*' (p.105). Paradigms are represented then by the way they respond to ontological, epistemological and methodological questions of inquiry. Thomas Kuhn (1970) introduced the notion of 'paradigms' to philosophy, suggesting that a paradigm is a very vague concept that includes almost everything, dependent on all of which makes it up, but yet not dependent on any one element in particular. '*A paradigm is a conglomeration of all of the background that affects how science operates, what questions it can ask, and what answers it can provide*' (p.32). The evolutionary development of science has been hallmarked by what Kuhn (1970) refers to as *scientific revolutions*, being junctures or turning points at which new paradigms emerged in society. Names associated with such demonstrations of changing paradigms were Copernicus, Newton, Lavoisier and Einstein (p.6). According to Kuhn (1970), all of these paradigm shifts brought about the rejection of a previously accepted scientific theory for one which was seen as incompatible to the previous. Each paradigm shift, however, while positively transforming the scientific world, always brought with it some resistance and controversy, being the defining characteristics of scientific revolutions (pp. 92-111).

A paradigm of inquiry, according to Sarantakos (1993), informs the researcher of '*what is important, what is legitimate and what is reasonable*' (p.30). All paradigms and methodological approaches are seemingly elaborate and complex, and within each appear inherent disagreements and anomalies amongst its proponents. Willis (2007) notes the '*exact number of these competing paradigms or worldviews and the names associated with a particular paradigm can vary from author to author*' (p.17), but suggests that positivism, post-positivism, critical theory and interpretivism are a generally accepted list within the social science domain. The discussion thus unfolds with the term positivism, coined by the French philosopher Auguste Comte (1798-1857), founder of the discipline of sociology.

Positivism

'T*he positivist fisherman standing on a riverbank (without getting feet wet) describes the social properties of a species of fish by observing the general tendency of their group behaviour as they swim around*' (Source: www.academia.edu).

Research has come through many '*paradigm eras*' according to Lincoln and Guba (1985), describing these as '*Pre-positivist, positivist and post-positivist*'. The positivist approach arises from that of natural science and is characterized by the testing of hypotheses developed from existing theory (hence theory testing) through measuring observable social realities. Denscombe (2007, pp.253-285) illustrates positivism as being focused merely on facts, gathered by direct experience and observation using quantitative methods such as experiments, surveys and statistical analysis. Thus, the ontological position of positivism is one of realism, where, for example, objects exist independent of the knower. Relative to the organizational context, Hatch and Cunliffe (2006) hold that positivists believe what happens in organisations can only be determined through classification and the scientific measurement of people's behaviour and systems. Perhaps the apparent lack of contemporary literature on positivistic approaches to service development and practice transformation may suggest the ineffectiveness of positivist approaches to inquiring into a social science system (such as the health care system where this inquiry takes place), which intrinsically involves human beings and ones meanings and values linked to the development of social services.

Not to consider participants as independent objects would according to Raelin (2008) '*ignore the participant's ability to reflect on a situation and act in accordance to that reflection*' (p.112). The positivist's perception suggests that the world exists externally and objectively, assuming that knowledge is only true if it is based on observations of such external reality; that theoretical models can be developed that are generalizable and that can explain connections between cause and effect which contribute to the prediction of outcomes. Therefore, the positivist's epistemology is one of objectivism, where the researcher and the researched are separate entities. Meaning thus resides within objects and independent of the researcher, where the aim of the researcher is to glean meaning from the object/phenomena researched (Crotty, 1998).

Although located in an alternative paradigm, action research does not reject positivism because of its reliance on certain positivistic methods for data collection; whereas the positivist claims the researcher ought to be separate from the phenomena researched and that data collection and analysis should not be contaminated by the researchers' preconceived ideas or opinions. In this regard, Martindale and Tomlin (2010) note that positivism claims all principles of action research adversely affect objectivity and consequently the inquiry's

validity and generalizability. Thus, characteristics of the positivist paradigm differ considerably from those of action research, and particularly participatory action research, where objectivity in an inquiry is not required in order to achieve validity, as other methods beyond objectivity exist to achieve this.

Rolfe (2006) suggests that for postmodern ironists there can be no rules or criteria to determine validity of a research project (p.13); rather he states that unlike the modernists, they don't accept that a rigorous application of Method to the research process guarantees validity or reliability in the research findings. Rather than confining themselves to one predetermined method, the ironist, Rolfe suggests, promotes flexibility and reflexivity in their approach to the research process, so as to accommodate emergent arbitrariness which frequently presents itself within a research inquiry.

Challenging such traditional-positivistic beliefs of the absolute truth of knowledge, the thinking that subsequently emerged from writers such as Locke, Mill and Durkheim (Smith, 1989; Phillips and Burbules, 2000), was termed post-positivism, representing the philosophical period following the traditional positivistic approach.

Post-positivism

'A *post-positivist fisherman supplements his/her quantitative observations of the social properties of a species of fish by wearing a wetsuit and conducting structured interviews of a random sample of fish to ascertain their reasons for swimming in accordance with the inferred social pattern'* (Source: www.academia.edu).

Post-positivism challenged the notion of an absolute truth of knowledge and proposed that researchers cannot be positive about any truth claims; that we may never know the absolute truth when seeking knowledge. Like the positivist, the post-positivist believes that reality exists, but takes the view that it can only be known imperfectly and by way of certain probabilities. One of the first thinkers to challenge positivism, the Austrian philosopher Karl Popper, argued that a post-positivistic approach includes a philosophy where causes may determine effects or outcomes, where a researcher, for example, will conduct an experiment aiming to identify and determine particular causes which influence particular outcomes (Popper, 1959). This philosophical approach is also described by Phillips and Burbules (2000) as reductionist, whereby the aim may be to reduce the phenomena into a small set of discreet ideas to test. The knowledge generated from the post-positivist perspective is based on

accurate measurement and observation of objective phenomena existing '*out there*' in the world. Therefore, researching the behaviour of individuals or groups by way of statistical measurements of observation is an example of the post-positivistic approach to research. In this regard the post-positivist approach does not aim to reject positivism, but rather illustrates the basic principles of positivism by employing experimental methodologies towards achieving possibilities of an objective truth. Denzon and Lincoln (2005) further assert that the post-positivist researcher interprets inquiry as a logical series of inter-related steps and believes in participants' multiple realities as opposed to a single reality perspective. Accordingly, the post-positivist stance suggests there is no absolute truth, that all observation is imperfect, and that all theories remain open to revision.

Lincoln and Guba (2000) say that although an evident contrast exists between positivistic (theory verification) and post-positivistic (theory falsification) perspectives, both paradigms contain more similarities than not and share theories that lead to prediction and control of phenomena. What the post-positivist rejects in positivism, however, according to Phillips and Burbules (2000), is the notion that there exists some basis of data from which valid knowledge claims can be systematically deduced, assuming a suitable scientific method is available. The post-positivist proposes then that though any knowledge produced is surely flawed or has some weaknesses, this position simultaneously does not suggest that any knowledge claims are inevitably false. The post-positivist thus argues that while there is no unquestionable foundation for knowledge, this does not mean that one should be sceptical of all knowledge claims or that knowledge validity is always relative to cultural or theoretical frameworks. In this regard, it is then not possible to achieve objectivity and neutrality. Smith (1993) maintains that researchers and participants can become central to the research process, aiming to make sense of their subjective reality and what meaning it may inherently discern.

Relative to this PAR inquiry, many characteristics also overlap with the post-positivist paradigm, particularly concerning the use of data collection methods such as observation and interviews. Also, triangulation methods are common to both the post-positivist and action research approaches in providing broader perspectives and improving validity. This inquiry has relied on positivist and post-positivist methods of data collection and analysis, both of which can be compatible with the empirical end of the AR continuum. This is not the situation, however, at the participatory end of the continuum, where participants collectively develop

and change social phenomena. Within strictly post-positivist and interpretivist approaches alone, the researcher is an outsider aiming to objectively learn, interpret and understand social phenomena, whereas the emancipatory and participatory tenets of PAR are the polar opposite to the positivist/post-positivist approach.

As alternatives to and developments from the positivist and post-positivist traditions, early 20th century critics began to introduce concepts including Interpretivism and Critical Theory to the social sciences.

Interpretivism

'T*he interpretive fisherman enters the water, establishes rapport with the fish, and swims with them, striving to 'understand' their experience of being in the water*'.

(Source: www.academia.edu)

Linked to the broad philosophical tradition of idealism, the interpretivist paradigm encapsulates diverse approaches, including constructivism, phenomenology and hermeneutics. Constructivism, for example, highlights the individual's ability to construct their own meaning of phenomena while rejecting the objectivist's perspective that meaning is contained within the world and disconnected from consciousness. The ontological position of interpretivism is relativist, suggesting that reality is subjective and differs from one individual to the next, while holding an epistemology of subjectivism based on real world phenomena (Guba and Lincoln, 1994, p.110). Interpretivists believe there can be more than one reality and more than a single structured way of accessing such realities; and that it is only through the subjective interpretation of and intervention in that reality that reality can be understood. Lincoln and Guba (1985) warn, however, that '*these multiple meanings are very difficult to interpret as they depend on other systems for meanings*' (p.86). Knowledge generated then from the interpretivist perspective is socially constructed and understood largely through subjective (individual) interpretations (Hudson and Ozanne, 1988), allowing researchers to follow more personal and less rigid approaches than the positivist's one; as Crotty (1998) asserts, '*reality...exists only in the way people believe it, so meaning is not created but constructed*'(p.146). This approach is more open to meanings elicited from human communication. As a consequence, it is possible to understand what is perceived as multiple realities. Interpretivists, therefore, aim to understand and derive meaning from particular experiences, ultimately leading to knowledge (data) generation and dissemination. The

researcher and informants are interdependent and mutually interactive with each other, and construct a collaborative account of a perceived reality. Interpretivists, therefore, focus on how people make sense of their world (how they communicate, how they think, sense and feel) and how they create their social world through their actions and interpretations of the world, whilst remaining open to new ideas throughout the unfolding of the inquiry.

Having been quite prominent in social research, interpetivism, according to Denscombe (2010) has allowed for and encouraged researchers to (a) study '*the bases on which claims to be objective*' are made and (b) to be more thorough as to '*how claims are made relative to theory production*', concerning the social world. This refers to relativism (that the researchers approach is the correct one); uncertainty (comprehending the manner in which one constructs ones social world); and rigour (allowing for an emergent research design and not necessarily statistical analysis). Emerging from this line of reasoning, Crotty (1998) reveals that social researchers began to adopt a more moderated aspect of positivism and post-positivism or critical realism that included crucial elements of the interpretivist critique relative to objectivity. In this, interpretivism can be criticized for its ontological assumption of subjectivity, since in selecting a paradigm most appropriately aligned with one's research question, one is being subjectively oriented towards a particular approach. Actively engaging in the PAR approach to inquiry, participants are being particularly subjective in that they are active participants in the inquiry process and not referring to any preconceived hypothesis. In terms of data collection, the interpretivist takes an objective stance while analysing the data, so as to inform the researcher about the relevant phenomena, disregarding the researchers' own preconceptions. Therefore, the interpretivist aims to interpret and understand social phenomena, while the positivist researcher aims to explain social phenomena, and the action researcher aims to collaboratively change and challenge social phenomena.

With thinkers and philosophers aiming to challenge and critique social phenomena, 1930s Germany saw the emergence of what became known as critical theory, an approach that later became associated with action research.

> '*The interpretive fisherman interprets his/her methods of interacting with the fish, remains doubtful about his/her ability to fully communicate with them and reflects on his/her own experience of being fish-like in the water*' (Source: www.academia.edu).

Critical theory

'*The critical fisherman enables the fish to perceive the pollution in the water in which they live, to find its source and to identify its harmful effect on their being in the water*'.

(Source: www.academia.edu)

The ontological position of the critical theory paradigm is historical realism, holding the view that reality has been shaped by social, political, economic, cultural and gender issues (Guba and Lincoln, 1994). While the positivist, post-positivist and interpretivist approaches focused principally on either explaining or understanding social phenomena, critical theory offers a critique of social phenomena, including a perspective of how things can be changed, developed or transformed (Bronner and Keller, 1989). The epistemology of this paradigm is subjectivism and, similar to interpretivism, is based on real world phenomena, where knowledge is both socially constructed and influenced by power relations within our society (Crotty, 1998). Originating from the philosophical works of Marx, Kant, Hegel and Weber, this theoretical tradition was developed in Germany by a group of sociologists referring to themselves as 'The Frankfurt School'. This approach asserts that research or inquiry should encompass the totality of social phenomena and that society or social phenomena should also be improved or changed comprehensively. The Director of the Frankfurt School's Institute for Social Research, Max Horhheimer, stated that critical theory ought to meet three criteria:

> *...it must be explanatory, practical and normative, all at the same time. That is, it must explain what is wrong with current social reality, identify the actors to change it and provide both clear forms for criticism and achievable practical goals for social transformation* (p.12).

Both the positivist and interpretivist approaches separate the researcher from what is researched, while critical theory acknowledges the relationship between subject, object, theory and practice. The underlying assumption of critical theory, according to Marcuse (1989) is that it is only through the transformation of all dimensions of society and the eradication of varying aspects of social division that human happiness is possible.

Smith (2011) links this also to the desire to improve society as in Aristotle's notion of praxis: his organizing disciplines as theoretical, productive or practical and distinguishing the *telos* or purpose that each serves. As Carr and Kemmis (1986) assert:

> *'The purpose of a theoretical discipline is the pursuit of truth through contemplation; its telos is the attainment of knowledge for its own sake. The purpose of the productive sciences is to make something; their telos is the production of some artefact. The practical disciplines are those sciences which deal with ethical and political life; their telos is practical wisdom and knowledge'* (p.32).

Discussing Habermas's philosophical basis for change in contemporary society, Williamson et al. (2012) refers to the various methodological approaches aligned with particular paradigmatic perspectives. For example, '*the empirical-analytical sciences' base is technical control of the natural world*', as in quantitative research, whereas methods employed in '*the historical-hermeneutic sciences are interpretive and practical*', allowing social phenomena to be interpreted and understood, as in qualitative research. The authors suggest that these two broad perspectives contain particular limitations in relation to developing or transforming aspects of organizations or society; that only the critical sciences have the philosophical and methodological capacity and wherewithal to facilitate such societal transformation and/or aims of organizational change and development such as in this inquiry. According to Williamson et al. (2012), action research is for Habermas a very appropriate methodological approach employed within the critical sciences as it is implicitly critical, with self-reflective processes and possibilities to challenge any political, organizational or social system. For Habermas (1976), truth is the outcome of '*rational agreement reached through critical discussion*' (p.183). Relative to healthcare systems, Koshy et al. (2010, p.12) also discuss the philosophical perspectives that underpin action research and refer again to the works of Habermas (1971, 1974, 1984) and Waterman et al. (2001) when highlighting the centrality of the democratisation process as the impetus for sustained change in the critical sciences. The authors stress that introducing democracy into the research process '*presents a challenge to the institutionalization of research which was viewed as exclusive and exploitative*' (p.102) and, by making it participatory, those who may have been previously excluded can now participate in and *with* others to actively inform the research process (Koshy et al. 2010).

Based on these considerations and the aim and objectives of this inquiry, critical theory could have been an appropriate philosophical perspective chosen to guide the methodological process. However, although elements of critical theory inform the research process, as an overall guiding philosophical perspective critical theory lacks the flexibility necessary to negotiate between conflicting political and organizational structures within the environment where this inquiry takes place. It was important that the philosophical underpinnings guiding the methodology ought to be practically oriented and facilitative of ongoing systemic change and development, rather than adopting a philosophical approach that may appear intimidating because of its innate criticality.

> '*The critical fisherman empowers the fish to organize themselves as a lobby group and protest to the Department of Marine and Fisheries, and he/she advocates on their behalf to have the river cleaned up.*' (Source: www.academia.eu).

Pragmatism

> *'The pragmatic fish working together themselves, put practical plans in place to stop water pollution and through collaborative action improve their environment'.*

Pragmatism emerged in America in the late 19th century and is associated with C.S. Pierce (1839-1914) who suggested that one's belief system was evident in how one behaved habitually under particular circumstances, and that pragmatism was more a technique to be used to find solutions rather than a philosophy or solution to problems. Defined as '*an approach to philosophy, primarily held by American philosophers, which holds that the truth or meaning of a statement is to be measured by its practical (i.e. pragmatic) consequences*' (Maurer and Githens, 2010, p.268), Pierce saw pragmatism as a technique with which to clarify ideas of belief, truth and inquiry, but also asserted that all belief claims are fallible and open to change (Reason, 2003).

Drawing on the views of Pierce, psychologist and philosopher William James (1842-1910), argued that our ideas and beliefs have only real value when they pragmatically work for us, or that an idea or belief was true if and when it worked in practice. Where Pierce believed that reality was independent of human speculation, James believed that reality is subject to change consistent with human desire and thus so is truth. James believed that an idea was true if it made an actual difference in a person's life, what he called the '*cash value*' of an idea. '*The whole function of philosophy ought to be to find out what definite difference it will make to*

you and me, at definite instants in our life, if this world-formula or that world-formula be the true one' (James W., 1906, p.11). Referring to James's classic book *Pragmatism*, Reason (2003) talks about G.K. Chesterton's notion that a lot can be said about someone by how they view life and the universe, suggesting that '*knowing someone's worldview is to know their temperament*'. In this context James suggests there are two types of temperament, what he called *the tender-minded rationalists* – philosophical idealists, religious believers and optimists – and *the tough-minded empiricists* – who generally dismiss religion and who are conditionally optimistic. James's philosophy includes being open to the notion of a mystical perspective of the universe, with a non-determined future incorporating an openness to human creativity.

After James's death, philosopher and educator John Dewey (1859-1952) applied pragmatism to the sciences and the social world where James' application was largely to religion. Dewey focused on social issues such as education and health. Westbrook's (1999) exploration of Dewey's text *Democracy and Education*, for example, suggests that education should not merely impart information on students. It should, he says, be pragmatic in that it should teach students how to solve problems, thereby providing them with tools to achieve success in the practical and scientific world (pp.2-5). This notion of practical application, of course, is particularly relevant to the aim and objectives of a PAR inquiry.

Relative to health, and in particular the teaching of nursing, Carper (1978) while referring to Dewey's (1958) differentiation between the concepts of '*recognition*' and '*perception*', describes four fundamental patterns of knowing distinguished by logical types of meaning, portrayed as: '*1. Empirics, the science of nursing; 2. Aesthetics, the art of nursing; 3. The component of a personal knowledge in nursing and 4. Ethics, the component of moral knowledge in nursing*' (p.23).

Over the 1890s Dewey moved from absolute idealism towards a pragmatic and naturalist philosophy, aligning his views with fellow pragmatist William James. In this regard, his subsequent theory of knowledge challenged such dualisms of 'mind and world', and 'thought and action', which have shaped Western philosophy since the 17th century.

An influential pragmatic philosopher of the late 20th and early 21st centuries, Richard Rorty (1931-2007), challenged the traditional philosophical aim of the discovery of *truth* in the *Philosophy and the Mirror of Nature* (1979), taking pragmatism in a new direction and

highlighting the *contingency of language* and how our vocabularies and sets of words we use justify our actions and our beliefs about reality. Discussing Rorty's pragmatism, McGlynn (2011) states:

> '*the rediscovery of Aristotle's vocabulary in the Middle Ages, the creation of a mathematical way of describing nature in the sixteenth century, the development of a Freudian vocabulary in the twentieth century are all examples of how a talent for speaking differently can provide people with a vocabulary to change their worldview*' (p.67).

Discussing language, Reason (2003) states that '*action researchers must find new language to describe their work, rather than be caught in the old academic metaphors of research*' (p.188). He also suggests that Rorty's ideas *re-describe* philosophy and in turn *action researchers re-describe inquiry*. Reason (2003) also refers to what Rorty called the many '*dualisms*' which he says go back to Plato's writings, including subject-object, researcher-subject etc. This '*taken for granted vocabulary*' has not been helpful and '*we must let go of and create our own vocabulary to describe what we take as quality in our research*' (p.194).

Consistent with PAR's worldview, McGlynn (2011) though the discussion is in the context of an economic downturn, emphasises that pragmatism offers hope, aiming to make the world a better place to live in, that no social system is unchangeable and that we also can change ourselves. Pragmatism '*offers the individual a liberating and optimistic outlook*' on life suggesting '*we should not be restrained by any abstract concepts such as 'facts' or 'the way things are'*", rather '*the most debilitating constraints are the limitations we put on our own thinking and creativity*' (p76). Pragmatism, he proposes, opens up a whole new future, full of hope and optimism, '*especially if we can free ourselves from any type of fatalistic worldviews*' (p.34).

Similarly, Wicks, Reason and Bradbury (2008) suggest that action research must not be seen as another methodology; rather, they suggest, it is an *orientation* to inquiry, where knowledge acquisition comes from '*responding to a real need in life*', and as a philosophical underpinning '*allows us to emphasize active experimentation*' (p.16).

The characteristics of pragmatism blend well with the present inquiry's aim and objectives and how these are achieved in this on-going practice development. Pragmatism's notion of truth being contained within day to day personal and professional settings, verified by actual stakeholder experience and in being fallible, is thus open to further exploration, suggests that theory cannot be separated from practice nor thought from action.

Practical Theory

'*There is nothing as practical as a good theory*' (Lewin, 1951, p.169).

Cronen (2001) formulates the following description of practical theory:

> '*A practical theory informs a grammar of practice that facilitates joining with the grammars of others to explore their unique patterns of situated action. The proximal reason for joining is the co-creation of new affordances and constraints for creative participation in the instrumental and consummatory dimensions of experience. Practical theory itself is importantly informed by data created in the process of engagement with others'* (p.26).

Practical theory is based on the notion of inquiry and pragmatism, where principles that are informed by engaging in the lived experience are employed to bring about change (Cronen, 2001). From the pragmatist's understanding of inquiry, Dewey (1938a) posits human inquiry as a natural and basic part of life, aimed at improving our situation by adapting to and being accommodated within the world around us. According to Dewey (1929/1960, 1938a), 'professional inquirers' adopt '*instrumentalities*', including: definitions, ways of thinking and propositions to demonstrate how they can make a difference in various real-life settings. In this, Dewey described inter-related activities, within which the inquirer fluctuates or moves. Utilising one's experience, the inquirer, informed by formal and informal instrumentalities of theory, brings about the following criteria of an inquiry process:

- *Identify the situation in view.*
- *Fashion instrumental descriptions and definitions for features of the situation and their relationships.*
- *Develop percepts of situational features and processes.*
- *Test formalisations and percepts by acting upon them.*

- *Form a 'judgement' that (a) integrates understanding of the situation into a unified whole, and (b) has clear implications for interventive action.*
- *Take actions based on the judgement.*
- *Assess the consequences of action on features of the situation including new elements of the situation because of the action taken.*

  Cronen (2001, p.21)

The term *percept* denotes one of the key features underpinning the philosophical approach of pragmatism in this inquiry. James (1911, p.1) introduced the difference between concepts and percepts, defining concepts as discrete entities independently existing from each other in what meanings they individually contain, whereas the perceptual flux is what it is directly perceived potentially by all of the senses; it is always '*a much-at-once*', containing numerous elements and aspects from which concepts can be formed. The percept '*can show duration, intensity, complexity or simplicity, interestingness, exciting-ness, pleasantness or their opposites*' (examples which emerged throughout this PAR process are illustrated in the following Cycle chapters).

Dewey (1939a) contends that when we inquire into a 'situation' we make and remake determinations of what elements ought to be included for the purposes of inquiry, called 'the situation in view'. Cronen (2001) suggests that the 'situation in view' is a provisional judgement, which may lead to the inclusion of further elements or elimination of others. In this, Dewey (1930) suggests that the inquiry's aims ought to remain constantly in focus, employing the term '*ends in view'* to describe '*foreseen consequences which influence present deliberation'*, emphasising that such phenomena are not elements that are outside the inquiry context, but that arise and function within it. Furthermore, Dewey suggests that successful inquiry involves the transformation/resolution of certain contextual situations, what he refers to as '*indeterminate situations'*, which need to be negotiated or worked through in order to proceed to the next 'situation in view' (p.223).

As discussed above, Pierce (1905, quoted in Burke, 1994), suggested that one learns the meaning of an element when one is guided in identifying it amongst other phenomena, including the exploration of definitions, models and descriptions. In this, the object of interest is interpreted in various ways, resulting in the emergence of a '*percept*' of the element of

interest. The formation of percepts are what Pierce referred to as a merging of the experience that the inquirer brings to the situational context, with phenomena that involves the actions taken by the inquirer. In this, theory informs the ability that the inquirer brings to their formation of percepts, in the flux of the action setting (pp.136-138). The particular nature of the percept, in turn, influences how action proceeds. From this, a 'judgement' indicates how the subsequent 'situation in view' may be influenced. In order to assess the consequences of those actions , Dewey (1938a, 1941) refers to 'warranted assertability', where emergent data demonstrates how one warrants systemic steps in the inquiry process, including forming descriptions and making connections between those and other descriptions as the inquiry process unfolds.

Cronen (2001) proposes the following criteria as crucial to the ability of a practical theory to meet the criteria listed above:

- *The instrumentalities of a practical theory should guide those activities of inquiry that develop, organise, test and reconstruct:*
    - *Percepts of the situation in view;*
    - *Provisional hypotheses about how particular percepts are related;*
    - *Systemic hypotheses (judgements);*
    - *Actions taken in the inquiry process;*
    - *Consequences implicated by actions taken beyond the original situation in view.*
- *A practical theory should provide sufficient guidance for the use of its instrumentalities. Definitions, descriptions, models and case examples all contribute to guiding its use. Meeting this criterion in not a matter limited to providing formal definitions with the form of analytic propositions.*
- *A practical theory should facilitate the creation of alternative systemic hypotheses. The details of experience are typically amenable to more than one coherent explanation. A single explanation blinds the inquiry process to alternatives and stymies an investigator when a particular line of inquiry is unfruitful.*
- *A practical theory should allow for further development of old methods and creation of new ones. As a practical theory is employed in a new and different kind of situation, methods may have to be developed or adapted in response.*

- *A practical theory should grow in the richness of its instrumentalities. Logical positivist theories depend on propositional form. The terms in a proposition are elaborated only by breaking them down into smaller component parts. In practical theory, by contrast, we look for richer, more useful ways to explore what is involved in the particular context.*
- *A practical theory should lead to greater sophistication for all parties involved, including the professional inquirer. Its use should make one a more sensitive observer of details of action, better at asking useful questions, more capable of seeing the ways actions are patterned, and more adept at forming systemic hypotheses and entertaining alternatives.*
- *A practical theory should provide instrumentalities for including the person using it as a part of the inquiry process. Practical theories reject both a subjective and objective understanding of inquiry. Thus they need to be able to take account of the practitioner as participant when that is useful* (pp.29-30).

These criteria inform and are pertinent to the methodological approach adopted in this PAR inquiry, elements of which permeate the write-up of the three Cycles below. However, Action Research (AR) is firstly introduced here, with participatory action research (PAR) discussed thereafter.

Action Research

The fish collectively decide to employ action research methodologies/researchers to develop a healthy environment in which to live.

Before exploring the particular methodological framework and characteristics of PAR, it is necessary to illustrate how it evolved from within the historical context of action research worldviews (Figure 1). Origins of action research '*lie in social psychology, the natural sciences, organizational science and social planning*' (Hart and Bond, 1995, p.36), and can be found in the works of John Dewey and Kurt Lewin. Dewey (1910) states that man is not an isolated being but one who must build bridges with others and with the natural and artistic world, and is constantly connected with an environment in a constant process of change. According to McTaggart (1997), Dewey's philosophical ideas, especially his criticism of the separation between knowledge and action, and his suggestions to link science and practice, were considered particularly influential in the evolution of the new scientific approach of the

time, namely action research. Masters (2000) concurs, noting that Dewey is not particularly associated with the concept of action research, but his significant contribution to the development of a variety of experimental approaches in the social sciences later paved the way for the evolution of action research. As McKernan (1991) notes, Dewey '*applied the inductive scientific method of problem solving as a logic for the solution of problems in such fields as aesthetics, philosophy, psychology and education*' (p.136).

Hart and Bond (1995, p.13) refer to the beginnings of action research in a text from 1926 entitled *Research for Teachers,* and also refer to John Collier's pioneering work with the north American Indians between 1933 and 1945. The authors also highlight the foreword to *Resolving Social Conflicts* (Lewin, 1948) written by G.W. Allport where the Harvard University Psychology Professor described Lewin as the '*psychological exponent*' of a form of democracy of which John Dewey was described as the '*outstanding philosophical exponent'.* McTaggart (1992) also highlights the earlier work by Gestettner and Altricher in 1913 Vienna, where a physician named Moreno used group participation in a community development project with prostitutes.

Lewin had a personal interest in applying action research to intergroup relations (Bargal, 2006, p.368). He worked in the USA during the Second World War, where his notion of action research was initially developed to mobilize the social sciences against authoritarianism. In his paper '*Action Research and Minority Problems*', Lewin described action research as a series of steps, including elements of planning, action, and fact-finding about the results of the emerging actions (Lewin, 1946). His model of change assumes that an individual or any social system will remain in the state it is unless confronted by an outside stimulus (Maurer and Githens, 2010). In his paper '*Frontiers in group dynamics'*, Lewin also stated that in order to bring about real systemic change it is often necessary to introduce a strategic methodology (Lewin, 1947a).

Definitions

Masters (1995) refers to three particular definitions of action research, which can relate to the particular aims and objectives of this inquiry:

1. *a systematic inquiry that is collective, collaborative, self-reflective, critical and undertaken by participants in the inquiry* (McCutcheon and Jung, 1990, p.15).
2. *a form of collective self-reflective inquiry undertaken by participants in social situations in order to improve the rationality and justice of their own social or educational practices, as well as their understanding of these practices and the situations in which these practices are carried out* (Kemmis and McTaggart, 1988, p.24).
3. *action research aims to contribute both to the practical concerns of people in an immediate problematic situation and to the goals of social science by joint collaboration within a mutually acceptable framework* (Rapoport 1970 as cited in McKernan, 1991, p.134).

More recently Hilary Bradbury-Huang provided this definition:

> '*Action research is an orientation to knowledge creation that arises in a context of practice and requires researchers to work with practitioners. Unlike conventional social science, its purpose is not primarily or solely to understand social arrangements, but also to effect desired change as a path to generating knowledge and empowering stakeholders. We may therefore say that action research represents a transformative orientation to knowledge creation in that action researchers seek to take knowledge production beyond the gate-keeping of professional knowledge makers. Action researchers' do not readily separate understanding and action, rather we argue that only through action is legitimate understanding possible; theory without practice is not theory but speculation. Our activist wing might summarize that action research takes knowledge creation to the people*' Bradbury-Huang (2010. pp.93-94)

Within these definitions are contained four key themes of action research, according to Zuber-Skerrit (1991):

- *the empowerment of participants;*
- *collaboration through participation;*
- *acquisition of knowledge;*
- *social change.*

The worldviews as illustrated by Titchen and Manley (2006), are presented here.

Action research worldviews

Figure 1 below illustrates the various action research worldviews from ontological, epistemological and pragmatic perspectives.

Worldviews	**Technical**	**Practical**	**Emancipatory**	**Transformational**
Philosophical Stance	Empiricism / Rationalism	Idealism	+ Realism	++ Metaphysics
Ontology /Epistemology	Objectivity is key, sense data determine reality	Emphasis on actors' ideas as determinant of reality	+ Social practice and culture shape practice	++ Philosophical inquiry of a non-empirical character into nature of existence
View of Persons	Instruments to carry out/ action	Individuality of persons	Welfare of the person & community	Transformation and flourishing of whole person & community
Knowledge	Instrumental *Explanation*	Practical Understanding	Practical + Emancipatory Reflection	Practical, Emancipatory + transformational
Practice development / Research paradigm	Empirico-analytical *Positivist*	Interpretive Constructivist / hermeneutic	Interpretive + Critical	Interpretive + Critical Creativity

Figure 1. Action Research Worldviews Source: (Titchen and Manley, 2006)

Action Research Worldviews

Technical AR is associated with a scientific method of problem-solving and evolved from doing social experiments on subjects in the 1940s and 1950s and with community development initiatives in the 1960s (McKernan, 1991). The positivistic-empiricist perspective is the philosophical stance from which this worldview is approached; the researcher, often an outside expert, aims to objectively test a particular intervention resulting in the collection of predictive knowledge (Grundy, 1982).

Practical AR, according to Grundy (1982), '*seeks to improve practice through the application of the personal wisdom of the participants*' (p.5). The philosophical perspective in this realm is idealistic where the ideas of practical action researchers aim to gain new understandings of practice and problem solving (McKernan, 1991). Outcome sustainability tends to be a concern employing this approach, as much of the focus tends to be on individuals involved in the systemic change process (Holter et al. 1993) rather than long-term organizational change. The theoretical perspective of Practical AR is hermeneutic which allows for flexible, interpretive and phenomenological approaches (McCutcheon and Jung, 1990).

Philosophical stance / emancipatory action research embodies realism. Masters (1995), citing Grundy (1987), states:

> '*emancipatory action research promotes emancipatory praxis in the participating practitioners; that is, it promotes a critical consciousness which exhibits itself in political as well as practical action to promote change*' (p.19).

Grundy (1982) refers to Habermas's (1972) theoretical model for understanding this approach, stating '*it is through the development of critique that the mediation of theory and practice is possible*' (p.43). The interaction between theory and practice in this approach incorporates the development of both during the course of the inquiry, according to Grundy (1982), where the acquisition of knowledge emerges from reflection; '*we see human flourishing of all stakeholders as the ultimate purpose of EAR, directed at enabling person-centred, evidence based healthcare through holistic transformation*' (Titchen and Manley, 2006, p.338).

Transformational AR, as described by Titchen and Manley (2006), involves stakeholders challenging taken-for-granted areas of healthcare '*in order to develop new insights into the oppressions, contradictions, dilemmas and paradoxes that prevent the delivery of person-*

centred, evidence-based healthcare' (p.341). Inspired by Carr and Kemmis's (1986) book *Becoming Critical*, the authors illustrate how individuals, teams, workplaces, organizations and communities use such understandings to transform their cultures and practices by collaboratively creating new knowledge in and from practice. This approach suggests that as action researchers, individuals and teams become *practitioner – researchers* investigating their own practice where the transformational process leads to the flourishing of the whole person, teams, organizations and the community.

> '*The practice epistemology of AR is about understanding the nature of emancipatory, transformational knowledge and the relationship between the known and the knower. This understanding enables the action researcher to develop methodologies that will deliver the kind of knowledge required in order to transform self, others, teams, contexts, cultures, organisations or community practices. The practice ontology of AR is about a way of being and what it means to be a transformational action researcher expressed through the body, spirit and practices of the action researcher as a person*'.
>
> Titchen and Manley (2006, p.352)

The theoretical perspective frequently applied to this approach is interpretive and critical creativity (Carr and Kemmis, 1986).

This general overview of the worldviews of action research (Figure 1) illustrates the evolution of action research, and where none of these particular approaches are fixed or completely separate from one another, such an overview facilitates the methodological choices available for an inquiry.

Principles of AR

- *AR combines a systematic study, sometimes experimental, of a social problem as well as the endeavours to solve it.*
- *AR includes a spiral process of data collection to determine goals, action to implement goals and assessment of the results of the intervention.*
- *AR demands feedback regarding the results of the intervention to all parties involved in the research.*
- *AR implies continuous cooperation between researchers and practitioners.*

- *The small group plays a central role for decision making for achieving change in people.*
- *AR takes into account issues of values, objectives and power needs of the parties involved.*
- *AR serves to create knowledge, to formulate principles of intervention and also to develop instruments for intervention and evaluation.*
- *Within the framework of AR there is much emphasis on recruitment, training, development and support of the change agents.*

Adapted from Bargal (2006)

Characteristics of Action Research

AR may be characterised within three broad areas: action research within organisational change as illustrated by Argyris and Schon (1991); action research within educational research (Kemmis and McTaggart, 2003); and participatory action research (Reason and Bradbury, 2001; Herr and Anderson, 2015). Reason and Bradbury (2001) argue, however, that there is no short definitive answer to precisely what action research is (p.1), suggesting rather that similarities and synergies merge within the process and goals of action research, which can be summarised as:

- AR is participatory, conducted by and with others, but not with outside or independent 'expert' researchers on people selected as research subjects. AR is collaborative and frequently involves all interested stakeholders in the research process.
- AR is a reflective and systematic process, often including cycles of planning, action, observation and reflection, while simultaneously being an emergent and flexible approach.
- AR is a democratic research process whereby researchers and stakeholders can be equal participants, sharing responsibilities and roles in all cyclical processes and functions.
- AR is frequently employed as a methodology aiming to effect previously agreed change, in areas of social justice and to improve the lives of the participants involved.

(Greenwood and Levin, 1998; Kemmis and McTaggart, 2003; Herr and Anderson, 2015).

In order for any research project/inquiry to take place, Grundy and Kemmis (1981, as cited in Grundy, 1988) suggest the necessary existence of the following three generic characteristics:

1. the project takes a social practice as its subject matter, regarding it as a strategic action susceptible to improvement;
2. the project proceeds through a spiral of cycles of planning, acting, observing and reflecting, with each of these activities being systematically and self-critically implemented and interrelated;
3. the project involves those responsible for the practice in each of the moments of the activity, widening participation in the project gradually to include others affected by the practice and maintaining collaborative control of the process.

In AR, participants in social programmes are also equal partners in research and have the right to join in the preparation and/or improvement process of programmes. AR requires collaboration of all parties related to the applications, such as students, administrators and the community. Thus, the data gathered by action researchers can reflect different sides of the issue, providing a more holistic perspective of the issue. The researcher then can develop interventions that can include a wider range of solutions.

Theoretically, there is no end for AR, as social issues are dynamic and in that dynamic structure issues arise all the time. Therefore, the intervention that is applied may solve one issue but new ones will appear and new interventions will be needed.

Relative to health and social care, Hart and Bond's (1995) book '*has a multi-disciplinary, inter-professional and inter-agency focus*' (p.46). The authors illustrate a typology of AR (p.40), which illustrates an evolving phenomenon originating from the scientific towards a more qualitative and social-constructionist methodological approach to social change. The typology identifies four types of AR: the experimental, the organizational, the professionalizing and the empowering. The experimental type is closely associated with positivistic and scientific approaches to problematic social issues and links to the '*technical*' worldview of AR (Figure 1) are evident. The organizational type associated with idealistic problem-solving and power- dynamic agendas within organizations can be correlated with AR's '*practical*' worldview orientation (Figure 1). The professionalizing type, often associated with practice-based research, contains many components that can be oriented from both 'practical' and emancipatory' worldviews (Figure 1). The empowering type, very much

associated with initiatives such as this inquiry, is often adopted within society's vulnerable groups such as those experiencing dual diagnosis. This type can embody the '*emancipatory*' and '*transformational*' worldviews (Figure 1).

In contrast to the varied sets of generic characteristics for AR outlined above, in exploring 'communicative action and emancipatory knowledge', Habermas emphasises that particular methodological considerations may depend on the environmental context of an inquiry. In this regard, both Greenwood and Levin (1998) and Kemmis and McTaggart (2005) assume a more pragmatic approach to AR, taking into consideration particular local and/or environmental/population concerns. Collectively, the authors' characteristics of AR can be summarised as:

- a social process, focused on the inter-relationship between an individual and their social environment;
- fundamentally participatory, where participants go to work on themselves, examining the relationship between knowledge, identity, agency and practice;
- practical and collaborative, in that it involves groups investigating their practices (including their relational practices);
- emancipatory, in that it helps people address the 'constraints of irrational, unproductive, unjust and unsatisfying social structures that limit their self-development and self-determination';
- critical in the way it encourages participants to contest the ways they are positioned to view the world in particular ways;
- reflexive in that the object of investigation is to change the world for the better in a number of ways: through practice, knowledge of practice and social structures;
- it aims to transform both theory and practice and views these as mutually dependent.

Action Research challenges

From exploring the alternative and competing paradigms above, the general principles and characteristics of AR seem to fit well with the aims and objectives of this inquiry. Considerable evidence exists which demonstrates the particular applicability of this approach within a health and social care environment, similar to where this inquiry takes place. However, as a methodological approach to inquiry, AR can contain certain challenges in its application. Simonsen (2009), for example, observes how AR can be time-consuming and

risky: '*an action research project must be initiated, established and carried out before you have the empirical data for your research*' (p.112). Simonsen further highlights that in comparison to alternative approaches, AR can be personally demanding and challenging. By definition, one is significantly involved in the project with particular responsibilities throughout the process:

> '*the action research project can be compared with the researcher's little 'baby' that carefully is nursed and protected*' (p.114).

A further challenge for AR is what Herr and Anderson (2015) refer to as '*Designing the plane while flying it*' (p.83). The authors note how some have thought of AR as having a '*lesser status*' to alternative approaches, an approach that '*informs practice but does not contribute to a larger knowledge base*'. In this, Brydon-Miller, Greenwood and Maguire (2003) suggest that because of the process of implementing action-oriented applications in a local context, this blending of expertise may '*offer more valid and convincing results*' than alternative approaches. These '*valid and convincing results*' are firstly fed back into the present service development setting (local knowledge) and thereafter are potentially transferable to other settings (public knowledge) which may contain many similar resources necessary for the initiation of such an implementation process.

Participatory action research (PAR)

> *The fish collectively agree to adopt PAR's methodological processes, aiming to live in a healthier environment. Underpinning this process they choose pragmatism as a guiding philosophical approach as they utilize appropriate technical methods of inquiry to inform the research. Through emancipatory and transformational ways of knowing they wish to sustainably flourish in their own community environment*.

Chevalier and Buckles (2013) overview the theoretical stances and methodological strategies applied to where PAR has created a lasting legacy. Though highlighting key challenges within PAR, Chevalier and Buckles emphasise that '*PAR must reflect and act on the complex factors that currently shape the course of human interaction*' (p.4). Tending to focus on solving practical problems or strengthening the interconnections of self-awareness, PAR, according to the authors, ought to be developed to accommodate a communicative action that bridges the gap between pragmatic experimentation and the human psyche.

Originating from the works of Marx, Adorno, Marcuse, Habermas and Freire, participatory and advocacy approaches were developed in response to resolving issues of social injustice often associated with the more marginalized groups in society (Newman 2000). Dual diagnosis service-users present with overlapping and complex needs requiring multiservice involvement. Historically, the mental health and addiction services have developed independently of one another, with either service not sufficiently structured to holistically assess and treat dual diagnosis, thus leaving the service-user marginalised and voiceless; (MacGabhann et al. 2004, 2010; Government of Ireland, 2006, 2009; Phillips et al. 2010). PAR's worldview holds that the participatory action element of the research process may help change the lives of the participants and improve the environment and/or organization in which they live or work. Discussing participatory and advocacy approaches to inquiry, Kemmis and Wilkinson (1998) describe participatory action as '*recursive or dialectical and focused on bringing about change in practices*' (p. 241). Thus, the ultimate aim or objective of an inquiry would be to motivate change. This worldview can also assist people in becoming more empowered within environments or settings where the notion of power may have become an influential or debilitating factor for some participants in an inquiry. Within such social structures, the emancipatory possibilities inherent within this worldview can facilitate personal, organizational and political change because of its practical and collaborative processes which actively involve participants with one another. Such worldview tenets were enthusiastically discussed amongst stakeholders when initially planning which methodological approach was most suitable to assist in this dual diagnosis service development. It was agreed that the practice ontology of the PAR approach was about a way of being and what it means to be a stakeholder in the inquiry, expressed through collaborative, participative and democratic ways of knowing, an approach which was amenable to all involved at the initial stages of the inquiry.

There are particular features of PAR which inform the research process:

> *'(a) a collective commitment to investigate an issue or problem, (b) a desire to engage in self and collective reflection to gain clarity about the issue under investigation, (c) a joint decision to engage in individual and/or collective action that leads to a useful solution that benefits the people involved, and (d) the building of alliances between*

researchers and participants in the planning, implementation and dissemination of the research process' McIntyre (2008, p.1).

For the initial stakeholders these features appeared to fit symmetrically with the aims and objectives of this current inquiry.

Considering the action research worldviews illustrated in Figure 1 above, PAR can be located between the emancipatory and transformational worldviews, though employing a mixture of methods from the technical end of the continuum during the inquiry process. Over the last three decades for example, PAR has been implemented throughout South America and in other developing countries (Brown and Tandon, 1983; Gaventa, 1988, Fals-Borda, 2001; Hall, 2001; Chevalier and Buckles, 2013).

Herr and Anderson (2015, p.17) highlight these general characteristics of PAR as described by de Schutter and Yopo (1981):

- *The point of departure for participatory research is a vision of social events as contextualized by macro-level social forces.*
- *Social processes and structures are understood within a historical context.*
- *Theory and practice are integrated.*
- *The subject-object relationship is transformed into a subject-subject relationship through dialogue.*
- *Research and action (including education itself) become a single process.*
- *The community and researcher together produce critical knowledge aimed at social transformation.*
- *The results of research are immediately applied to a concrete situation.*

  Schutter and Yopo (1981, p.68)

This set of characteristics for participatory action research (Schutter and Yopo, 1981) are most applicable to and identifiable in service developments and transformations within healthcare generally (Hsieh, 2012; Williamson et al. 2012; Allan et al. 2015a; 2015b), and within the agreed pragmatic approach to the current inquiry in particular (Connolly et al. 2015).

Adopting a PAR framework for this inquiry

As described above, the general mental health and addiction services have evolved and developed independently of each other, with certain objectives of integration in the context of

dual diagnosis having been expressed both nationally and locally (MacGabhann et al. 2004, Government of Ireland, 2006; Government of Ireland, 2009; MacGabhann et al. 2010; Connolly et al. 2015). The co-location of the addiction and mental health services in the environment of primary and community care services in Cork (Connolly et al. 2010) provided the ideal forum from which a specific dual diagnosis service could evolve (MacGabhann et al. 2004). As the worldviews of the mental health and addiction services may differ, be separate and historically have had considerable inter-communication difficulties, potential challenges in this regard necessitated a comprehensive and rigorous approach to participation and collaboration towards this service development. PAR provided a methodology that could embrace such challenges and furthermore provided a framework where service-users and their families could participate together with those representing multiple disciplines in a collaborative power-sharing process. Service-user participation and knowledge is both recommended and central to mental health service policy development (Government of Ireland, 2006, 2009), and PAR's philosophy and methodological possibilities made this choice the most suited approach to meet the aims and objectives of the inquiry (Stringer and Genat, 2004; Koch and Kralik, 2006a; Lazes, 2007; Rahman, 2008; Drake and Bond, 2010; MacGabhann et al. 2010; Berg-Powers and Allaman, 2012; Khan et al. 2013; Schwartz et al. 2013).

Stakeholders further agreed that this cyclical framework (a) provided a basic mechanism from which the complexities of the subject under study could be explored, (b) was easily accessible to all participants, and (c) blended well with the organisation's service development methodologies. However, Bradbury (2016) argues that Lewin's model is archaic, suggesting that novice researchers ought to access more contemporary models while conducting transformational social science, and to look at their own experience of the world as they approached their work; also that many action researchers, including Israel et al. (2013) and Stringer (2014), for example, have adopted non-cyclical approaches in contrast to Lewin's model, an approach also encouraged by Bradbury (2016). Despite Bradbury's sentiments, however, the justification for employing Lewin's cyclical approach is because of its efficacy in the particular environmental and stakeholder context of this inquiry. An overview of my work routine within the organisation led to a realisation, prior to embarking on this inquiry, that much of our day-to-day business within this health service involves *planning* change,

where our *actions* (work practices) are generally *observed* and measured individually and collectively, followed by *reflective* practice, which is central to the entire process. On this basis, and also considering other stakeholder factors (described above and in the Methods chapter below), it was collectively decided to employ a re-branded version of Lewin's original-cyclical approach. With this clear objective in mind, the Cycles of inquiry below illustrate how we have contemporised Lewin's model in a focused way. Moreover, the decision to employ Lewin's model was from a philosophical basis of pragmatism, which acknowledges the complex organisational environment where this inquiry takes place, where the day-to-day reality for core stakeholders with serious mental illness and addiction issues (described above) can be so unpredictable.

As an employee within the organisation's primary care addiction service, my position in the inquiry is as a *hybrid* insider. Having been in this role prior to the inquiry, I had established certain links and professional relationships with work colleagues and service-users. However, assuming lead researcher in the inquiry has shifted my positioning both in the inquiry process and as a consequence in my day-to-day roles. This seems to be a fluid process and will be reflected in more detail in the various Cycle chapters as the process evolved. For some time as an employee within this public health care system, I have participated in and observed much discussion about the lack of a specific dual diagnosis service and, importantly, how people in our communities were suffering because of this. Like many others I had accepted and become accustomed to the status quo. On this I am reminded of the work of Chris Argyris whose main concern was '*the ability of organisations to learn*' (p.15) and who saw communication as central to organisational change (Argyris et al. 1985). Drawing on the previous work of Dewey and Lewin, Argyris developed intervention strategies for changing the status quo. According to Argyris et al. (1985):

> '*In social life, the status quo exists because the norms and rules learned through socialization have been internalized and continually reinforced. Human beings learn which skills work within the status quo and which do not work. The more the skills work, the more they influence individuals' sense of competence. Individuals draw on such skills and justify their use by identifying their values embedded in them and adhering to these values. The interdependence among norms, rules, skills and values creates a pattern called the status quo that becomes so omnipresent as to be taken for*

granted and to go unchallenged. Precisely because these patterns are taken for granted, precisely because these skills are automatic, precisely because values are internalized, the status quo and individuals' personal responsibility for maintaining it cannot be studied without confronting it.' (p.xi)

When organisational change is both a desired outcome and is happening through a cycle of planned actions, it is, of course, inspirational and exciting for many stakeholders, but as Herr and Anderson (2015) point out '*many institutions may not be thrilled at the idea of close examination*' (p.39). Argyris's work is helpful to us as participatory action researchers in this regard because unless practical solutions to the issues being examined penetrate the complexities that underlie and maintain the status quo, then practices will only be resolved in the short-term and/or superficially. The sustainability of this service transformation in the context of dual diagnosis has been planned for strategically throughout the process of inquiry and is detailed in the Cycle chapters below.

PAR's emancipatory philosophy allows us to be oriented towards the elicitation of human potential and to inquire into the power within the individual, the organization and society. As Carr and Kemmis (1986) assert, the aim of this type of research is '*the emancipation of participants from the dictates or compulsions of tradition, precedent, habit, coercion or self-deception*' (p.195). These complexities can be deeply ingrained within the individual and organization, but through a process of critical self-reflection and discovering different ways of knowing can lead to transformation. The methods by which such processes occurred are detailed in the next chapter.

Position and context of the inquiry

Being an *insider* action researcher, employed in this (HSE) organisation and within this inquiry, the issues and challenges relative to being an insider researcher will be explored in more detail in each Cycle chapter and in the Critical Discussion chapter. However, it is appropriate to mention here that particular challenges exist for the insider action researcher in the context of role duality concerning the ethics of insider action research. Holian and Coghlan (2012) explore these challenges further in relation to '*dual and multiple roles of researchers in insider action research, contractual and covenantal agreements, planning and doing action research and recommendations about how to address ethical issues in insider action research*' (p.405). Because positions can shift many times during the inquiry process, positionality can

be referred to as being on a continuum (Herr and Anderson, 2015). Albeit challenging, in comparison to positivistic - quantitative approaches, one's positionality in action research is not neatly pigeon-holed; however, this methodological approach embodies reflexivity, allowing the researcher to be critically aware of positionality at all times.

My journaling, written observations and reflections of the evolving processes during the inquiry will both confirm and continue to shape my ontological and epistemological positions in the inquiry. These are detailed in the Cycle chapters. However, it is useful here to discuss the relevancy of this position ontologically. Working in the environment of primary and community care and as part of a multi-disciplinary team, I interact primarily with the mental health and the broader addiction services in the south-west sector of Cork city. Employed as an addiction counsellor, I provide services in the primary care setting whilst collaborating with the primary care multi-disciplinary team, the mental health team and related services. I have been in this '*hybrid'* position since 2008. Prior to taking up this post, I worked in the specialist addiction services where an identified need for a dual diagnosis service in the region was regularly expressed, a need that was also identified nationally (MacGabhann et al. 2004, 2010). From the time of co-locating mental health and addiction services (Connolly et al. 2010), the collective endeavour was to continue to develop a comprehensive response for dual diagnosis in collaboration with service-users. Importantly, the input from service-users was discussed from the start in accordance with recommendations outlined in the publication *A Vision for Change* (Government of Ireland, 2006).

My transference from specialist addiction services to the environment of primary care and the development of links with the mental health team and other participating disciplines in the community provided a foundation from which a local dual diagnosis service could evolve. However, considering PAR's philosophy and methodology, one's personal background is also of particularly significance. If I had not had a particular personal interest in the subject of dual diagnosis, this inquiry may not have started. Of course, the inquiry is part of an academic programme with a personal objective for me to achieve an academic qualification; but this academic objective fits with a professional and personal satisfaction at co-participating in the development of a dual diagnosis service. In relation to the aim and objectives of the inquiry, from an organizational perspective, I am what I chose to call a *hybrid-insider* in the inquiry.

Inevitably my position as a participant in the inquiry process impacts on the research process and the methods employed; however, the democratic and emancipatory philosophy of PAR allows all stakeholders to equally participate in the development of this dual diagnosis service where power sharing in terms of knowledge, position or experience was a previously agreed upon objective.

As a qualitative research methodology, PAR is regarded as a democratic, liberating and life-enhancing approach or '*orientation to inquiry*' (Reason and Bradbury, 2008, p.1). Considered as a derivative of action research, PAR can be distinguished from other qualitative approaches, particularly in the context of researcher positioning and stakeholder participation (Reason and Bradbury, 2001; Kemmis and McTaggart, 2007; Snoeren et al. 2011). The following Cycle chapters describe in more detail how participation for many stakeholders started and changed through the various cyclical processes and also how levels of engaged participation varied. As the inquiry is community based, chapters on Cycles One and Two illustrate how participation was an evolutionary process and included further stakeholders from the community.

Health care policy for some time has included terms such as participation, collaboration, integration and partnership. What these terms suggest may seem ideal when discussed in conjunction with service development objectives such as this, while consideration ought also include the varying degrees of participation (Webler et al. 2001) and that '*participation is not expressed by a single way of behaving*' (Mortero, 2000; Grant et al. 2008). Service developments directed by heads of departments are normally policy driven (Government of Ireland, 2006, 2009), thus often compromising participation and collaboration. This inquiry, however, emerged from the ground up in the absence of government policy direction, and thus facilitated the process of participation.

CHAPTER FOUR: METHODS

In her book *Night Falls Fast*, which explores teenage suicide, Kay Redfield Jamison states: '*The breach between what we know and what we do is lethal*'? Participatory action research (PAR) and its myriad of methodological approaches to inquiry can support the objective of bridging such tremendous gaps whilst also adding significantly to what we know (Fals-Borda and Rahman, 1991; Park et al. 1993; deKoning and Martin, 1996; Seligman, 2002; Cooperrider et al. 2004; Stringer and Genat, 2004; Reason and Bradbury, 2006, 2008; Khan et al. 2013). This chapter describes the research design and methods employed in this inquiry, aiming to bridge the gap between knowledge and action in service provision for dual diagnosis in one primary health care area of Cork city.

PAR's methodological approach facilitated a transparent environment for active communication and critical reflection among stakeholders throughout the Cycles of inquiry (Schwartz et al. 2013). Frequently employed in the area of health service development (McDaid, 2006; Watters and Comeau, 2010; Berg-Powers and Allaman, 2012), PAR contains an emancipatory potential and empowering philosophy which can benefit stakeholders when actively participating in the research process (Kock and Kralik, 2006). The specific choice of methods was crucial in stimulating and maintaining stakeholder engagement in the development of this new service. The inquiry's aim and objectives (p.16) focused on collectively including stakeholders (health service staff and service-users) who were situated in diverse positions and roles within the overall service. In order to create this necessary forum of engagement, the core research group explored a variety of cyclical frameworks to determine suitability to this particular inquiry. Figure 2 below illustrates Lewin's (1946/1997) original four-step cyclical process (Kemmis and McTaggart, 1998; Stringer and Gental, 2004; McIntyre, 2008) which was selected and adapted to the local context of this PAR inquiry. This methodological approach was agreed by stakeholders as an appropriate and robust method for stimulating service development in this particular environment.

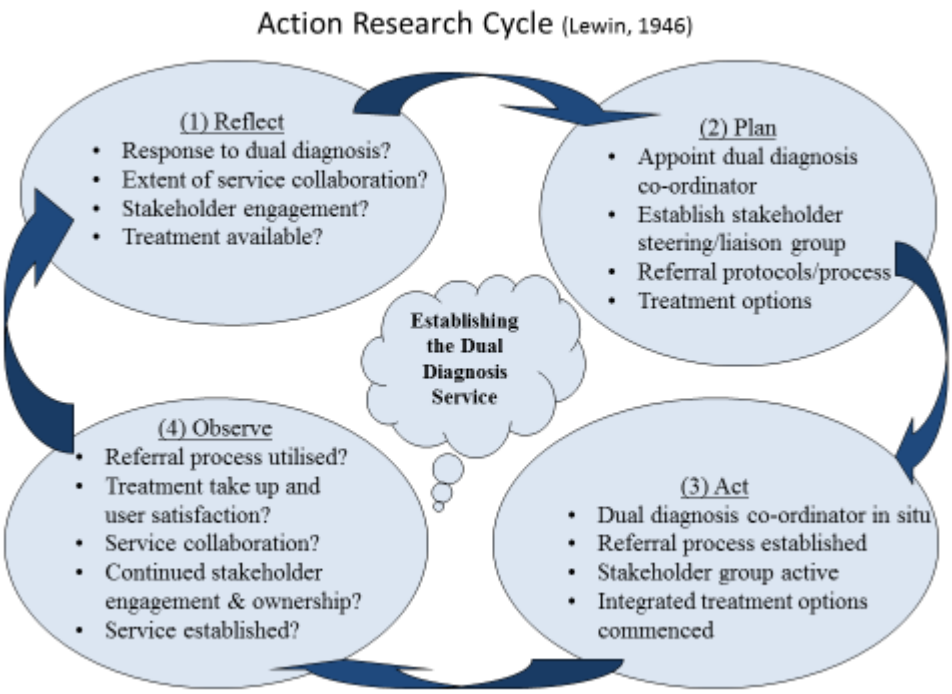

Figure 2. Action Research Cycle

Lewin's (1946/1997) cyclical model of change was adapted to the particular context of this inquiry. Three Cycles of inquiry occurred in this research process. The *reflection, planning, acting* and *observational* phases of each Cycle of inquiry facilitated an open but structured forum for communication and critical reflection amongst stakeholders. Moreover, this methodological forum allowed stakeholders to meet and collectively engage in these iterative processes which alternative methodologies may not have provided.

This chapter illustrates how the inquiry Cycles have traversed and pragmatically engaged with Lewin's *unfreezing/refreezing* model of change whilst embodying the aim and objectives of developing a dual diagnosis service within the public health care system. The 'unfreeze/refreeze model' blends well with the positive approach to service/organizational development and with the tenets of PAR. The active stakeholder integration and processes of engagement which led to this service development (illustrated in the Cycle chapters) was made possible by the adoption of this methodological approach.

Engaging stakeholders by creating participatory structures

The research was focused on those who participate and interact with the evolving dual diagnosis service within the HSE's primary care geographical environment of Togher/Ballyphehane in the South Lee area of Cork city. Specifically, the inquiry took place in the Togher community centre, the GF ward (South Lee Mental Health Services, acute ward) in Cork University hospital (CUH), Tiernann Phadraig (Community Mental Health Services building), Kinsale Primary Care centre and St. Finbarr's hospital.

Initial stakeholder engagement commenced once the approach (PAR) to dual diagnosis service development was agreed with my research supervisor after receiving approval from my line management to develop the service/initiate the inquiry. I then applied for ethical approval which was granted in April 2013. This process initiated engagement with peripheral stakeholders, including doctors and consultant psychiatrists of the Clinical Research Ethics Committee of the Cork Teaching Hospitals.

PAR relies critically on the initial development of relationships, what Dick (2000) refers to as the '*entry process'* (p.12). Participating stakeholders included practitioners, service-users and family members who were locally engaged in the referral, assessment and treatment of those experiencing dual diagnosis. Within this geographical area, the organisational disciplines of psychiatry, mental health, addiction, social work, psychology and occupational therapy and the discipline of general practice (being outside the HSE organisation), all participated at varying levels in the iterative cycles of inquiry. Cycle One included the initial stakeholder identification and engagement process which evolved into an '*unfreezing*' phase of the inquiry with clinicians and alternative practitioners such as GPs, service-users, family members and counsellors participating in this collaborative approach (Connolly et al. 2015, pp.31-33).

More details about my organisational position are relevant here. One of the unique strengths of this inquiry was my position within the research context. I had worked within the organisation for 15 years, specifically working in a primary care addiction service which integrated with the local mental health services. From 2008 to date I have been based in both Togher/Ballyphehane and Kinsale primary care areas of Cork city, so my working week includes both sectors, with the inquiry located only in the Togher/Ballyphehane area. I already had developed a working relationship with varied disciplines/stakeholders in this sector and was thus quite well known, which greatly facilitated the initial engagement (Connolly et al.

2010). All of this experience meant my being considered as an insider by most of the participants, expressed through their lack of guardedness or reluctance to be open and transparent about their actions or opinions, as I seemed to be perceived as one of them. For example, during some of the interviews and in the critical reflection groups and informal conversations, stakeholders frequently said to me 'Y*ou know what I mean*' and 'Y*ou know how it is around here*', signifying our collective familiarity with the environment and positioning within the organisation. However, what became clear as the inquiry unfolded was that although I was perceived by many participants as an insider, I was in fact what I have chosen to call a *hybrid-insider* as I was not confined to any one particular service or department within the organisation. Thus I was able to integrate with and between teams and services in varying departments.

It was also clarified from the outset (proposal phase) that the PAR inquiry included a service development objective and an academic objective. In this regard both Coughlan and Brannick (2010) and Zuber-Skerritt and Perry (2002) elaborate on the differentiation between the *core* action research project and the *thesis* action research project. This apparent dichotomy was a particular challenge for me in Cycles One and Two as, for example, I found it seemingly unmanageable at times to maintain a balance between (a) fulfilling my job's responsibilities, (b) actively participating in the day-to-day challenges of the service development, (c) maintaining chronological journaling and observations and (d) simultaneously writing initial drafts of various chapters for the dissertation. This, however, is very much part of the PAR process, as partially illustrated in Figure 3 below. In order to remain focused and to manage what frequently seemed unmanageable, I used my reflective journaling (Boud, 2001) to dictate what I was experiencing, thinking and feeling; in clinical supervision I could thereafter regularly process the experiences ('*learning about learning – or meta-learning*', Coughlan and Brannick, 2010, pp.11-13), and as such transfer what seemed unmanageable into positive or more coherent elements of the service development ('*bridging knowledge and action in the work-place*', Raelin, 2008, p.37). These challenging experiences often precipitated a personal growth spur, as I integrated this aspect of the methodology relative to my internal world of thinking, feeling and experiencing and how I managed and shared relevant aspects of this with my support structures such as supervisors and critical colleagues and, when appropriate, other stakeholders in the inquiry.

> ‘*Since PAR leads researchers into previously unfamiliar pathways, involvement in the process is likely to stimulate us to think in new ways about old and new theoretical problems, thus generating provocative new ideas*’.
>
> Whyte, Greenwood and Lazes (1989, p.538)

Core research group

The participants of the core research group included service-users and representatives of the various disciplines, including nurses, CNM II, community mental health nurses, mental health social workers, occupational therapists, psychiatrists, psychologists, psychotherapists and addiction counsellors. Many stakeholders engaged with this research group and with the decision-making processes at varying degrees and in an undetermined fashion. Over the cycles roles changed regularly.

Research supervision and critical PAR practitioners

Regular contact with supervision from my research supervisor was a guiding principle throughout the inquiry. Becoming inevitably immersed in the inquiry process, it was difficult at times to objectively see or make sense of what was happening. The interaction with critical colleagues was a welcome way of reflecting on the process outside of the inquiry context. We met every six weeks in UCC. Clinical supervision on a monthly basis also provided some objectivity for reflection outside the inquiry. Meeting with PAR practitioners from the university and from other local healthcare settings outside of the inquiry context enabled me to gain perspective on fine-tuning nuances in the inquiry.

Triangulation

According to Flick (2007), the use of triangulation reflects an attempt to gain a deeper illustration of the topic in question, while reminding us that ‘*objective reality can never be captured, only knowledge of something can be gained through its representations. Triangulation is not a tool or strategy of validation but an alternative to validation*’ (p.22). The author emphasises that the combination of multiple methods, perspectives and observations in a single study is best understood as a strategy that adds rigor, richness and depth to any inquiry.

The aims and objectives of this inquiry's research blend well with the employment of varying methods of data collection and analysis, at different phases of the inquiry process, whilst simultaneously being embodied in an underlying pragmatic philosophy.

> '*There is no doubt among researchers in the field about the importance of including participants who experience the reality or phenomenon studied in research debates, as they provide an insider's view that richly contributes to the development of more thorough results*'.
>
> Gomez (2014, p.86)

This integration of approaches, according to Creswell and Plano-Clark (2011), can occur within philosophical or theoretical frameworks, within methods of data collation and analysis, in general research design and/or in the discussion of research results. The objective of implementing this approach is to aim to provide a greater or more comprehensive illustration of the research topic or phenomenon that otherwise may not have been accessible by the adoption of a singular approach alone (Shannon-Baker, 2015).

Ethical considerations

> '*Everything's ethics*' (Cochran-Smith and Lyle, 2007, p.24).

Employing PAR's methodological framework suggests doing research *with* and *for* people rather than *on* people. Thus participants become collaborators rather than research subjects, as is the case in traditional or positivist approaches to research. The philosophy of collaboration, and particularly the evolving nature of PAR in this inquiry process and consequent service development, has elicited some ethical issues. This is to be expected when engaging in a PAR process, as the approach to research is different to the traditionalist approach because of our subjectivity (Cassel, 1982; DePoy and Hartman, 1999; Morten, 1999; Lincoln, 2001; Williamson, 2002; Williamson and Prosner, 2002; Boser, 2006; Brydon-Miller and Greenwood, 2006; Cochran-Smith and Lytle, 2007).

Ethical approval was granted for this inquiry (Appendix M.). The participatory and action-oriented nature of the research context indicates that participants can be affected by the research process at any time. Engaging participants as co-researchers in the collaborative approach is a negotiation process which, according to Hart and Bond (1995), ought to include

the ethical guidelines concerning the research process. In this regard, Research Operational Guidelines (Appendix A.) were outlined by the core research group for the inquiry.

Data gathering

Quantitative data were gathered to measure the referral numbers from various sources to the developing service over a fixed period of time in Cycle Two. Quantitative data were also gathered from stakeholders in the form of surveys which allowed stakeholders to anonymously express their opinions on aspects of service developments. Qualitative methods, including focus group discussions and individual interviewing, were methods planned for throughout Cycle Two. Participant observation and journaling were also methods used throughout the inquiry. Stakeholders also engaged creatively in poster design groups which encouraged further participation. Methods employed were not merely for data collection purposes, but provided a creative space for communication, interconnectedness and service transformation.

Data were gathered and documented in chronological form due to the evolving and cyclical nature of the research. Stakeholders planned in Cycle One that if data were managed in a systematic and logical fashion where possible, that this would greatly facilitate both the integrity of the data and the subsequent analytical process. I created a series of Word documents that were dated and filed in relevant folders, with back-up files and folders created on a work laptop and USB key. Such data included journal entries and observations, memos, drafts of internal policy/procedures and service framework documents, minutes of transformation group meetings, minutes of critical reflection peer group meetings and qualitative interview schedules. My work email address and another personal Gmail account also recorded relevant correspondence. Personal reflections or journaling were also collected in diary form.

Data were also gathered from other sources, including relevant literature (see Chapter 2), participant observations within the organization and attending PAR study groups.

Qualitative Interviewing

Qualitative data were collected from an extensive series of interviews conducted with participants. In this regard, stakeholders in a reflective phase of Cycle One identified that the particular focus of (a) participants' perspectives or lived experiences, (b) the subjectivity and action-based stance of the researcher(s), and (c) the commitment to organisational change

were appropriate characteristics of this PAR inquiry. It was collectively agreed that the outcomes from the implementation of a series of interviews would help ascertain (a) stakeholder perspectives of various aspects of service provision and what was lacking and (b) the status quo of nuances within the organization locally.

Interviews, according to Schultze and Avital (2011), can generate particular personal accounts of participants' lived experiences and *their* understanding of such. The dialogic experience occurring during interviews can be cathartic for interviewees by providing a forum in which they could express their views and feelings (Holloway and Wheeler, 2010). The authors also suggest that structured interviews ought to be limited to processes such as the collation of socio-demographic data. The core research group decided a series of unstructured and/or semi-structured interviews would be more appropriate to the aims and objectives of the inquiry. Stakeholders agreed that the implementation of such methods of data collation were critical to the validity and authenticity of the inquiry process, as stakeholders' thoughts and experiences could be explored in-depth whilst thus generating rich data (Ryan et al. 2009). Consideration ought to be given to the subjectivity of particular stakeholders, especially of the dual diagnosed population who may have mental health experiences possibly affecting their recollection of past experiences. Both Moyle (2002) and McCann and Clarke's (2005) studies discussed such nuances in the context of unstructured interviewing. They suggested that researchers employing such methods should really follow the direction of the participants' storytelling which could be guided by *'aides-memories or agendas'* (p.76).

As the interview process can include the discussion of sensitive issues, it is also important that ethical considerations be explored prior to implementation. Doody and Noonan (2013) explore these issues in the contextual environment of nursing, while further suggesting that nurses '*possess the essential skills for interviewing and many of their skills are transferable*' (p.87). Such transferability appeared to be evident over the course of Cycle One and as Cycle Two unfolded, particularly in the various group discussions. As individual interviewing seemed a natural method of data gathering, so too was the suggested method of focus group interviews, as in Cycles One and Two much of the cyclical processes of planning and reflection occurred naturally in a group context. The core research group agreed that continuing this format would be conducive to all and would again potentially elicit rich data from an environment evolving over time. Further, according to Lambert and Loiselle (2008), the combination of

implementing individual interviews with focus group interviews particularly enhances the richness of the data. However, Fals-Borda's views on engaged inquiry and knowledge making are broad, but perhaps also relevant here in this inquiry context:

> '*Do not monopolise your knowledge nor impose arrogantly your techniques, but respect and combine your skills with the knowledge of the researched or grassroots communities, taking them as full partners and co-researchers. Do not trust elitist versions of history and science that respond to dominant interests, but be receptive to counter-narratives and try to recapture them. Do not depend solely on your culture to interpret facts, but recover local values, traits, beliefs and arts for action by and with the research organisations. Do not impose your own ponderous scientific style for communicating results, but diffuse and share what you have learned together with the people, in a manner that is wholly understandable and even literary and pleasant, for science should not be necessarily a mystery nor a monopoly of experts and intellectuals*'.
>
> Fals-Borda (1995, p.9)

Fals-Borda's suggestions resonate with the approach to inquiry adopted over the three Cycles of inquiry. Firstly, the methods of data collection chosen were those that were most suitable to the participants themselves, with all stakeholders also invited to participate in data analysis. Furthermore, as findings emerged from each Cycle, reflective groups included multiple stakeholders, who discussed and shared the individual and collective learning from the research process.

Focus group interviewing

Focus group interviewing, another qualitative data collation method employed by researchers in the social and behavioural sciences for more than 80 years, is today deemed an authentic and rigorous methodology (Oluwatosin, 2005; Redmond and Curtis, 2009; Doody et al. 2013). Historically, positivistic epistemologies were the norm, and it is appropriate to highlight here the positioning of focus group interviewing as an accepted and legitimate qualitative methodology reflected both in current health care practice and in contemporary literature (Bryman, 2004; Freeman, 2006; Krueger, 2006; Redmond and Curtis, 2009; Silverman, 2010; Chevalier and Buckles, 2013; Israel et al. 2013).

Redmond and Curtis (2009) describe focus groups as having particular emphasis on meaning rather than measurement, suggesting that ideally '*researchers immerse themselves in other peoples' lives'* (p.24) so that the interview process is more naturally conversational. This organic process of stakeholders becoming very familiar with one another occurred over Cycles One and Two in the inquiry, thereby allowing for the creation of a focus group process to emerge. Furthermore, as Krueger (1994) indicated, participants may be more willing to openly express their perspectives and interact with one another when they perceive others in the group as similar to them. This was an identification concept we had previously experienced and observed in both the service's psychotherapy group and core research group, and one which most likely formed a natural basis for the introduction of the focus group process.

Nevertheless, no matter how familiar stakeholders are with the group forum, both Fern (2001) and Freeman (2006) emphasise the criticality of careful planning and preparation in order for the process to be positive, noting that the research question ought to ultimately guide how the focus group is constructed. This construction should, according to the authors, include sufficient participants to yield diversity while limiting numbers to maintain comfort levels. Over Cycles One and Two of the inquiry, any of the groups have rarely exceeded 10 in number; for the purpose of the focus group processes, the core research group agreed that groups with a maximum number of 8 was appropriate.

> '*The challenge is to work with a methodological and philosophical singularity in the art of doing research 'with people', in lieu of doing it 'on them' or 'for them', and not betray the spirit of dialogue that guides the construction and transformation of history*'.
>
> Chevalier and Buckles (2013, p.10).

Focus groups employ a moderator/facilitator to utilise group dynamics and observe interactions as a means to gathering data on particular issues. Stewart et al. (2007) highlight the key role the facilitator takes, suggesting that ideal characteristics include being a good listener and responding appropriately to the discussion and to non-verbal cues. Further, the facilitator has functions prior to, during and after the interview. Krueger and Casey (2009), for example, highlight the importance of welcoming participants, providing a clear outline of the topic of discussion and explaining the purpose of the interview. Suggested criteria for conducting effective focus group interviews have been referred to by Doody et al. (2013):

'The interview should address the maximum range of issues relevant to the topic; sometimes researchers unintentionally restrict the discussion by presuming which issues are important. The discussion should include issues the researcher already knows about and issues that have not been anticipated.

The discussion should provide data specific to the topic and give detailed accounts of participants' experiences.

The discussion should promote interaction that leads to participants' feelings being examined in some depth – the aim is to promote a discussion that is deep and rich, rather than vague and general.

The moderator should take note of the personal context that participants describe when responding on a topic. The context in which participants describe their experiences is important, these are the personal factors that make an individual describe an experience in a certain way. Often, people are unaware of their own perspectives until they interact with others. The whole point of a focus group is to create an environment that brings together a variety of these perspectives'.

Adapted from Merton et al. (1990, p.16)

Qualitative interviewing and PAR methodology

Consistent with PAR and relevant to the research question, findings are discussed in narrative form and are illustrated in each Cycle chapter. However, PAR is about more than generating knowledge, it is an *'emergent, evolutionary and educational process of engaging with self, persons and communities'* (Reason and Bradbury, 2001, p.12). This dissertation provides particular focus on the methodology and on the resultant transformations which occurred from the implementation of relevant methods of data collection as the service became established and also at individual-participant levels during the research process.

'Action research is a participatory, democratic process concerned with developing practical knowledge in the pursuit of worthwhile human purposes, grounded in a participatory worldview which we believe is emerging at this historical moment. It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people,

and more generally the flourishing of individual persons and their communities'.

Reason and Bradbury (2001, p.1)

Traditionally, qualitative interviewing is associated with the researcher independently gathering information from people who are being studied (Wiles et al. 2006; Stephens, 2007). Critically in the context of PAR and this inquiry, this is not so. PAR's approach to gleaning data from stakeholders is participatory, that is, where it emerges from an emancipatory, equality and interconnected philosophy allowing researchers to gather data *with* stakeholders as co-researchers. In keeping with PAR's democratic emphasis, all participating interviewees, including organisation employees, service-users and carers/family members, were provided with an explanation of the research inquiry's aims, an overview of the Cycles and the purpose of the interview.

The interview style was exploratory, in-depth and face to face, using open-ended questions in a conversational manner. The interview approach was agreed by the core research group as being an appropriate and compatible method of data gathering. This method was aligned with PAR's approach and particularly relevant to the aims and objectives of the inquiry, thus providing a forum in which stakeholders' voices could be heard and individual experiences considered in the shaping of the evolving service. Qualitative interviewing was also believed to empower stakeholders by acknowledging their lived experience and involving them in considerations for planning and reviewing actions: '*they provide the opportunity to gain an account of the values and experiences of the respondent in terms meaningful to them*' (Stephens 2007, p.205).

Interview Sampling

All interviewees were provided with an inquiry information sheet (Appendix E) and a consent form (Appendix B).

All interviews were recorded on a hard drive Dictaphone that had a built-in USB connection, so interviews were easily uploaded onto a computer and filed accordingly in chronological form. All interviews were transcribed and themes were colour-coded (see Data Analysis examples for each Cycle in appendices, G, H and I. For colour coding/categorisation example see Appendix K).

Participant numbers are accounted for within each of the Cycle chapters, with documentary evidence of protocol, procedures and guidelines relative to the service during the inquiry/service development process listed in Appendix (J).

Participant observation

> '*As the centre of interest of observations becomes less personal, less a matter of means for effecting one's own ends, and less aesthetic, less a matter of contribution of parts to a total emotional effect, observation becomes consciously intellectual in quality……in short, observation becomes scientific in nature*'.
>
> Dewey (1933, p.93)

Although not a dominant data collection method in this inquiry, the method of participant observation was a thread that permeated all Cycles, where data emerged regularly which informed further planned actions. Participant observation is a data-gathering method employed as part of this mixed method approach to inquiry which put researchers in contact with co-researchers to '*generate practical and theoretical truths about human life grounded in the realities of daily existence*' (Jorgensen, 1989, p.14). Because of my position in the inquiry, participant observation was used as a particular method for the triangulation of varying data sources and stakeholder perspectives. As lead researcher, I was an active participant and an observer both in the inquiry and within the system. Furthermore, the core research group had regular contact with other stakeholders, and shared observations which emerged in this context were of critical importance to planning further actions based on agreed upon service developments.

The method of participant observation also enabled my ability to include theoretical insights throughout the Cycle chapters, which were particularly relevant to the academic requirements of this inquiry as a PhD dissertation.

Furthermore, an important element of this methodological approach was the ongoing recording or documentation of '*field notes*' or journaling. As a participant observer I consciously recorded reactions, thoughts and feelings, and with such observations as were collectively explored and analysed by stakeholders. Importantly, it was the stakeholders' views that impacted on the data collection, interpretation and the next steps planned for. Though originating from the '*ethnographer's toolkit*', the recording of events within the realm

of participant observation '*is a contextualised and systematic process*' (LeCompte and Schensul, 2010, p.44), and one which has blended well with PAR in this inquiry.

Reflective journaling

Within the environment of teacher education, the concepts of '*reflective thought*' and '*reflective action*' were pioneered by John Dewey (1933) and Donald Schon (1987), and more recently employed as data gathering tools within the realms of action research and related approaches to inquiry (Whitehead and McNiff, 2006; Taylor, Rudolph and Foldy, 2008; Lamb, 2013). Dewey (1933), for example, suggested that reflective writing practices are mainly concerned with the researcher processing/documenting their personal research experience, rather than on the perceived outcomes of the research. This method, once made transparent with others, he suggests, helps validate the authenticity of the gathered data.

Journaling has been a practice I have engaged in throughout the inquiry with the initial objective of helping me not to forget what may be easily forgotten, but primarily suggested by my supervisor as a helpful method to assist me in the writing up of the Cycles of inquiry. In the process, I discovered that this method of data collection developed my knowledge and experience of reflexive practice (Etherington, 2004), captured the original experience of the moment, facilitated its transference to others thereafter, and created a forum from which to reinforce or check out my own understanding of what I had documented. Walker (1985) describes that writing within this realm also elicits objectivity; it is, he contends, a process of distancing oneself from the original experience and, importantly, of differentiating between the actual experience and the various possible interpretations of it, when explored with others. Schon (1987) further suggests that writing in this way creates a more honed focus on one's ideas. The process, individually and collectively, helped connect experiences with other past experiences, old knowledge with new and theory with practice. The active practice of journaling and taking risks by sharing the contents with other stakeholders, particularly the core research group and in supervision, helped me appreciate the actual process of reflection within learning. Furthermore, the collective process generated for me a greater sense of ownership and confidence in journaling as an effective method of data gathering and knowledge generation.

In discussion about writing for ourselves and others in research, Kim Etherington highlights her understandings in the context of reflexivity as:

> ‘*Reflexivity requires self-awareness but is more than self-awareness in that it creates a dynamic process of interaction within and between ourselves and our participants, and the data that inform decisions, actions and interpretations at all stages of research…. it opens up a space between subjectivity and objectivity that allows for an exploration and representation of the more blurred genres of our experiences…..adding validity and rigour in research by providing information about the contexts in which data are located*’.
>
> Etherington (2004, pp.36-37)

Collating theoretical-reflective insights provided a guiding influence for my own analysis in the overall inquiry process. These reflections helped shape and guide theoretical discussions with my supervisor, with critical colleagues and with the core research group, particularly in the context of adopting variable data collection methods as the Cycles unfolded.

Data analysis

Consistent with methodological approaches to research including PAR, data analysis began in this inquiry at the very beginning and continued to guide plans for further decision making as the inquiry unfolded and the service developed. In this, a particular challenge throughout each Cycle was that many decisions had to be made prior to the data being gathered in order to make progress. An example is appropriate here: the core research group would convene as pre-arranged and because of annual/sick leave or staff changes the attendance might be smaller than usual. The agenda for such meetings often included action plans to be discussed which were pertinent to ‘current’ service developments. Action decisions taken in this context were often made without the complete participation of all stakeholders, so strictly speaking the analysis of the data was often incomplete, but it was critical that decisions had to be made immediately. Herr and Anderson (2015) reflect this point:

> ‘*The realities and timelines of the practice setting often collide with the researcher’s desire for more time for reflection and meaning making. To be able to freeze-frame the whole endeavour while further analysis is pursued is not often a luxury offered to the action researcher; in part, ones task is to speak out of what one has discovered thus far, while holding the awareness that the data and analysis have more to offer than what one has currently had the chance to thoroughly explore*’ (p.101).

Data analysis took place within each Cycle (see examples of data analysis process in appendices G, H and I) and was relative to the methods employed in that particular Cycle. However, from the experience of '*designing the plane while flying it*' (Herr and Anderson, 2015, p.83), data analysis became a developmental and cyclical process in itself, where an initial analysis of the data was essential for decisions to be made at particular junctures as described above. Thereafter as appropriate, when many stakeholders convened, a secondary and more complete participatory data analysis took place (see 'data analysis' section in each Cycle chapter), which informed the larger conversation. Initial content analysis of the focus groups in Cycles One and Two, for example, were carried out by participating stakeholders, with secondary group interaction analysis carried out by the core research group. These were examples of what could occur pragmatically within the research process as it became part of what Koshy et al. (2011) refer to as a more '*fluid, open and responsive*' ethos, rather than individually or collectively aiming to adhere to the strict idea of the traditional action research Cycles.

Even though most of the methods employed in this participatory process of inquiry have included other stakeholders, as lead researcher I have played a central role in all of the methods of data collection and analysis discussed throughout the three Cycles. For example, I gathered and filed data chronologically in Word documents with backup files on a secondary computer at the end of each week throughout the Cycles, with a view to managing the data systematically. This was necessary for the integrity of the data as it was gathered and for the subsequent data analysis. These documents included: minutes of multiple meetings, development of policy documents meetings, training schedules, processes and decisions; core research group agendas, minutes, plans and decisions; individual/personal reflections and observations I documented in small pocket-size notebooks, annual diaries and large notebooks. Organising the data in this systematic, transparent and orderly manner, established a solid basis in order to easily access and analyse the data. Data included individual interview data, participant observation data, case study data and data derived from field notes. The method chosen to analyse the data was thematic analysis. A widely used qualitative analytic method (Boyatzis, 1998; Roulston, 2001; Braun and Clarke, 2006), thematic analysis has been recommended as a '*useful method for working within the participatory research paradigm, with participants as collaborators*' (Braun and Clarke, 2006, p.97). Though thematic analysis

procedures are relevant to and are illustrated in each Cycle chapter, it is appropriate here to provide an overview of my role in the analytic process.

For this PAR inquiry, thematic analysis was chosen as a method to analyse data because of its applicability to respond to the particular aim and objectives of the research question (p.16). The aim and objectives of the inquiry collectively include the active participation of stakeholders in the development of a new dual diagnosis service. In this, I have chronicled stakeholder participation in each of the Cycle chapters, which is explicit in terms of each individual's sense of meaning about the particular element of the service development being processed. PAR's methodology in this context has provided the forum on which each stakeholder could express their individual voice/meaning, and actively participate in the evolving processes of service development and data gathering. This process allowed me as lead researcher, and service-users and other staff members as equal participants, to democratically discuss the matter at hand and co-generate the data to be analysed. Thematic analysis provided a flexible method for this data analysis which can provide a rich, detailed account of that collective meaning contained within the qualitative data gathered (Willig, 1999; McLeod, 2001).

The analysis started in Cycle One, during data gathering phases, when patterns of meaning and matters of interest to the research question began to emerge. As lead researcher, my own note taking was ongoing and the data that emerged from the analysis was frequently discussed and processed with other stakeholders and continued to shape the service as it developed. In this, Ryan and Bernard (2000) highlight the point that themes which emerge from patterns in the data can often occur in this non-linear fashion (pp.778-780).

As described in the Methodology chapter, action research can be generally complex. In particular to this inquiry, however, the data analysis occurred in real time, allowing for the ongoing analysis to dictate decisions related to the continuous development of the service. This exemplified the necessity and applicability of such a flexible method of analysis in the context of responding to this inquiry's aim and objectives (p.16), allowing for data to be gathered and analysed as the Cycles evolved. In this regard, this method of analysis allowed me as lead researcher to plan, organise and actively participate with other stakeholders in the democratic analysis process. Silverman (2010) reflects this point, stating:

> ‘S*uch analysis is a pervasive activity throughout the life of a research project. Analysis is not simply one of the later stages of research, to be followed by an equally separate phase of writing up results*’ (p.218).

Throughout the collective analysis process I gathered reflective theoretical insights in my pocket notebook, which guided and influenced my own analysis and contributed to further discussion of that analysis with other stakeholders.

In addition to the analysis processes above, I managed the data derived from the qualitative, semi-structured interviews differently. I systematically grouped the recorded interviews which I had transcribed myself, copying and filing all materials on two computers and hardcopies in filing cabinets. I accessed and downloaded the N-Vivo 10 computer software package from DCU’s ISS support system, using its search engines and query functions to identify trends and patterns in the qualitative data. Re-reading the data many times allowed me to be completely immersed in the data. However, having conducted the interviews, I came to the analysis process with some prior knowledge of the data and also with some thoughts and observations which I had documented in a notebook. I read all the transcripts once before I began coding, where probable patterns, themes and meanings began to emerge. Once thematically coded, the transcripts provided a conceptual framework for further analysis. I coded the interviews using a system for tagging the varying themes emerging with different coloured highlighters. I found this system manageable, efficient and transparent for the overall data analysis. Collectively, these systematic processes of data analysis led to further (individual and group) analysis and established a robust system of data management. This section illustrates how data analysis was conducted, employing the six phases of thematic analysis (Braun and Clarke, 2006) as a method of capturing information from what was changing in practice.

Data analysis method

In keeping with PAR’s principles, from the outset I aimed to facilitate the data analysis processes collaboratively. As stakeholders in this inquiry brought with them a wide variety of perspectives and experiences generally, it was agreed that the data coming from each data source be kept separate, so that the findings could be clearly analysed.

The following systematic stages of analysis are discussed here:

1. *Familiarising ourselves with the data.*

2. *Generating initial codes.*
3. *Searching for themes.*
4. *Reviewing themes.*
5. *Defining and naming themes.*
6. *Producing the report.*

1. Familiarising ourselves with the data

This section describes how we reviewed and became familiar with the data. The inquiry process benefited greatly from the fact that PAR facilitates data analysis as an ongoing process, enabling actions to be implemented which required immediate effect. Such actions required multiple stakeholder collaboration, and other times two or three participants were sufficient. The particular context or level of importance of the situation dictated the duration of the decision-making process and the number of stakeholders required. Participants generally agreed from the outset, that when immediate (and maybe less significant) decisions were required, common sense should prevail. However, in relation to the significant decision-making processes relevant to the core service developments, a systematic analysis process began with an ongoing review of the data. The data came from field notes, logbooks, journals and diaries, individual interviews, participant observation and two case studies. The contents from these sources were photocopied for each core research group participant, with the source (i.e. psychotherapy group) written on top of each page, identifying the origin of the data. As the Cycles progressed, with data being updated from day to day, data for analysis by the core research group was also being photocopied and updated. The objective of this analytic review was to identify data relevant to the service development issues emerging, and to inform the decision-making process relevant to the overall aim and objectives of the inquiry. Regular decisions were made to distinguish the relevant from the peripherally relevant data, and to choose which data to include in further processes of analysis.

This initial data review allowed stakeholders to become familiar with the varied plans, ideas and thoughts for service development. This developed into a sense of familiarity within the core research group where participants began to openly discuss the emerging findings. These regular meetings facilitated a process of moving backwards and forwards through the data, by

way of ongoing discussions of shared ideas specifically related to the field notes and to the objectives of the inquiry.

This enabled all core research group participants to become deeply familiar with all aspects of the data, leading to meanings and patterns then being sought and discussed. As facilitator (at this stage) in this process, I continually updated notes of these discussions, which in turn also informed the ongoing decision-making process.

Once the data was reviewed and stakeholders were very familiar with the data, the process of searching for meaningful words, phrases and sentences began.

2. *Generating initial codes*

This section gives an overview of how codes were generated from the data and where units of meaning were identified. As Herr and Anderson (2015) note:

> ‘R*esearchers are called on to make meaning and then take action that will intervene in the site and test the questions being explored, this meaning-making often feels partial but the process demands considered action to be further set in motion and studied*’ (p.90).

The data sources provided written (field notes, logbooks, journals and diaries) and recorded (interviews) data from participants, which was analysed manually by the core research group after the initial data review. Photocopies had been made of pages containing original data, with the original data remaining intact, while the photocopied pages were those reviewed and analysed. Transcribed data from interviews were also photocopied for collective analysis. Features of the data which seemed interesting or relevant to the inquiry’s objectives were then highlighted by the core research group. We interactively took turns highlighting initial codes or units of meaning from the texts by circling individual words, phrases and sentences with a pencil. The agreed focus in isolating these words and statements was to identify information that represented the perspectives and experiences of all stakeholders. As Denzin (1989) highlights:

> ‘*Interpretation is a clarification of meaning. Understanding is the process of interpreting, knowing, and comprehending the meaning that is felt, intended, and expressed by another*’ (p.120).

Discussions during analysis included the method and means by which data had been collected. For example, stakeholders agreed that the collective note-taking of phenomena in the inquiry was a valid verbatim record of what stakeholders had said.

At times during the analysis phase, through the generation of codes and interpreting meaning from the data, immediate action was required, while other concerns or themes highlighted required further analysis and exploration.

Keeping the research question in mind, the data was organised into initial categories and colour coded, with coded headings which were mutually agreed. Participants agreed to keep the coded headings open to revision as the process of analysis was continually updated and to continue to code for as many potential themes as possible, while aiming to maintain context in terms of words/phrases used. In this process, multiple themes across all categories were identified, but with focus on immediate decisions.

3. Searching for themes

After the initial categorisation of the data, different codes were identified, including the identification of potential themes. In this, many codes were combined to form over-arching themes, with some codes forming themes of their own. Some of the initial codes went on to form main themes, while others became sub-themes, and more were stored as peripheral data to be used otherwise in the inquiry.

The findings created varying numbers of themes and sub-themes in the analysis for each Cycle. All themes were reviewed and refined until agreement was reached that the data matched meaningfully, and that there were clear distinctions between each theme. The selected examples of headings and excerpts from the data analysis of each Cycle of inquiry given in the Cycle chapters represent those collectively chosen by the core research group.

4. Defining and naming themes

Once the themes were identified, they continued to be defined by the core research group, as they related to the overall aim and objectives of the inquiry. In this, each theme was discussed for its own merit and meaning, and in how it related to the other themes. For example, specific decisions on theme-related aspects of the service development that were agreed as having preference were implemented whenever the analysis group believed was necessary. Themes also emerged, which were agreed to be more appropriate for later stages of the development.

5. Producing the report

The 6th component of Braun and Clarke's (2006) approach to thematic analysis is the production of the completed report. The write-up of the data analysis in the Observation phase of each of the three Cycles of inquiry below aims to formulate the completed report.

Concerning organisational-insider bias, Herr and Anderson (2015) highlight:

> '*The tacit knowledge that a practitioner acquires over time working in a site raises epistemological issues in the sense that unexamined, tacit knowledge of a site tends to be impressionistic, full of bias, prejudice, and un-interrogated impressions and assumptions ought to be surfaced and examined. Furthermore, insiders, because they are often true believers in their particular practices, are too often tempted to put a positive spin on their data. For this reason, mechanisms for dealing with bias need to be employed*' (p.44).

Examples of the application of Braun and Clarke's (2006) approach to data analysis over the inquiry are available in the appendices (Appendices G, H, I and K).

Theory generation

> 'T*he whole idea of action research is that the kind of theory that is most appropriate for explaining its processes is already within the practice, and emerges from the practice as the research develops*'
>
> Whitehead and McNiff (2006, p.2)

Through engaging stakeholders in this inquiry, the identified aims and objectives were collectively formulated with the intention to develop a dual diagnosis service in a community setting by way of PAR. Other than this objective, no other hypothesis was made, though initial participating stakeholders agreed that through collaboration and dialogue a new sustainable service could be developed. Each Cycle chapter individually illustrates what emerged as the inquiry unfolded, and what theories of practice were generated within the live practice of service development.

In relation to the generation of a practical theory, the question must be asked: can all the methods employed, journaling, observation, individual and focus group interviews and questionnaires, on their own achieve this? The answer is that they probably cannot unless

there is also in place a concerted effort by all the stakeholders to have a collective focus throughout the cyclical processes of PAR.

> '*The core of action research is the constant confrontation of reflection and action, theory and method, theory and practice aimed at producing understanding and effective action*'.
>
> Dick and Greenwood (2015, p.195)

The learning which has encompassed the generation of theory in this PAR process has relied on the foundational guidance and inspiration gleaned from some of the critical comments and questions of the founders of pragmatism, Dewey, Pierce and James (see the Methodology chapter). For example, Pierce (1902) suggested that inquiry was only as good as its outcomes or practical and meaningful consequences in our lives, where clarity must be achieved and for us to act authentically on what we say to be true. In this, Pierce's version of pragmatism is ultimately social and collaborative, while William James (1908) much later highlights the particular limitations of hard science when it comes to making sense of the various ways human beings go through life. In this, James focuses then more on the thinking and experiential processes of the individual, giving little attention to the social construction of knowledge.

However, even though the individual and participative processes of inquiry were carried out in a pragmatic spirit, the constructs of the Cycles facilitated the various methodological choices described above. These in turn created a forum for particular personal and group reflection which ultimately was a social experience. Albeit informing the conversation and the inquiry, the individual's or researchers' perspective is just that. Inquiry is ultimately about what works, from what Dewey and Bentley (1949) call the '*many transactions of social and natural history*' (p.84) within the realms of the particular community of inquiry. Dewey (1927) again suggests that these many '*transactions*' of the mind, the community and the world must be developed within communities of inquiry, where engaged research facilitates the processes of inquiry and the actions that emerge from such.

In keeping with Pierce's view about clarity and the need to act authentically on what we believe to be true, participants in a PAR inquiry can take a particular stance on what it means *to know*, thus forming the basis for generating a practical theory. Chevalier and Buckles (2013)

suggest that researchers have choices in taking this stance, choices aligned, they say, '*mostly with fear or mostly with pleasure*' (p.52). The pursuit of absolute objectivity and detachment inherent in dogmatic and positivist science, the authors comment, are '*borne of fear, fear of human error*' (p.53), and with the uncertainty to be sure. Alternatively, what it means *to know* can emerge from the polarised position of the pleasure principle according to the authors:

> '*The pleasure of being and knowing is an invitation to acknowledge the engagement of mind, otherness and the world we live in, mutual commitments that science can never dissolve into component parts*'. (p.66)

The distinction between quantitative and qualitative approaches and contrasts with a combined pragmatic approach are illustrated by Morgan (2007) who emphasises the impossibility '*to operate in either an exclusively theory or data driven fashion*' (p.71). Morgan offers this organisational framework (see Figure 3) for understanding what the pragmatic approach can contribute to mixed methods approaches to inquiry and the generation of theory.

A Pragmatic Alternative to the key Issues in Social Science Research Methodology:

	Qualitative Approach	**Quantitative Approach**	**Pragmatic Approach**
Connection of theory and data	Induction	Deduction	Abduction
Relationship to research process	Subjectivity	Objectivity	Inter-subjectivity
Inference from data	Context	Generality	Transferability

Figure 3. (Adapted from Morgan, 2007).

Morgan suggests many ways how pragmatism provides options for methodological issues in the social sciences. In relation to the connection between data and theory, Morgan indicates how the features of induction and deduction clearly distinguish qualitative and quantitative research. However, as is illustrated in each of the inquiry's Cycle chapters below, the process of moving between data and theory generation has neither been linear nor one-directional.

> ‘*Engaged research is pragmatism at work; it is meaningful because it serves a practical purpose and is grounded in real life*’.
>
> Chevalier and Buckles (2013, p.64)

Fortunately, the pragmatic approach to this inquiry has supported the various methods employed. Furthermore, the greatest aspect of this approach has been how the relationship between any epistemological issues about the nature of knowledge produced, and any technical issues about the particular methods used to generate that knowledge have been emphasised and illustrated throughout the inquiry process.

From this, in the *Handbook*’s concluding reflections, Reason and Bradbury (2008, p.703) discuss ‘*the nature of knowing*’, referring to Victor Friedman’s remark that ‘*the war with positivism is more or less over*’ and Lyle York’s calls for ‘*robust epistemological awareness with flexible and adaptable methodology*’. PAR’s worldview and its inherent processes of engagement, whilst embedded within the philosophical approach of pragmatism, has within this inquiry developed many ways of knowing, aligning with the authors’ definition:

> ‘*Action research is a participatory, democratic process concerned with developing practical ways of knowing in the pursuit of worthwhile human purposes. It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of the individual persons and their communities*’.
>
> Reason and Bradbury (2008, p.4)

From this basis of theoretical understanding in practice, how can we exhibit quality in our research and by what criteria should quality be judged? Elements of the practical theory criteria outlined above became central to each of the Cycles of inquiry. Findings from each Cycle informed the evolving process, where emergent percepts guided the practical building blocks upon which the service developments took place. In this, participants engaged in the cyclical processes of inquiry below, iteratively realising the inquiry’s shared aim and objectives.

Methodological rigour

'*From the perspective of AR, rigor involves demonstrating that the interpretations and designed actions really work in context*' (Greenwood, 2015, p.205).

As discussed in the Methodology chapter, the traditional dominance of positivism held the concepts of reliability and validity as being closely associated with rigour. However, the paradigm within which PAR resides requires its own quality criteria, is eclectically based on its own terms, which is increasingly evident in the literature (Reason, 2006; Whitehead and McNiff, 2006; Stringer, 2007; Reason and Bradbury, 2008; Coghlan and Brannick, 2010; Dick, 2011; Levin, 2012; Chevalier and Buckles, 2013; Coghlan and Brydon-Miller, 2014; Dick and Greenwood, 2015; Greenwood, 2015).

If '*rigour*' is defined as '*the quality of being thorough or meticulous*' (Silverman, 2010, p.255), it must be our collective objective to assess quality in our research so that it can generate theory and where its validity can be judged by clearly communicated standards of judgement. Reason (2006) proposes questions of quality in action research, suggesting participants be aware of such choices and the necessity for clarity and transparency with stakeholders throughout the research process. Questions of quality include:

- *Is the research explicit in developing a praxis of relational participation?*
- *Is the research guided by reflexive processes for practical outcomes?*
- *Does the research include a plurality of knowing which ensures conceptual – theoretical integrity, extends our ways of knowing and is methodologically appropriate?*
- *Does the research engage in significant work?*
- *Does the research result in new and sustainable infrastructures?* (p.194)

Bradbury (2010) also suggests what constitutes quality in action research, citing the following criteria:

- *Proceeds from a praxis of participation.*
- *Is guided by practitioner's concerns for practicality.*
- *Is inclusive of stakeholder's ways of knowing.*
- *Helps to build capacity for ongoing change efforts.*
- *Choose to engage with those issues people might consider significant* (p.99).

Rigour, relative to the realm of PAR, refers to how data are generated, gathered, explored and evaluated through the many Cycles of inquiry. Aimed at practitioner researchers, Whitehead and McNiff's (2006) book looks closely at what quality means in action research. While departing from traditional social science criteria and standards of judgement, the authors propose an alternative approach to quality assessment and evaluation which merges well with an inquiry such as this. The authors note that criteria and standards of judgement are different concepts, criteria taking the form of words or phrases used as markers of performance indicators. The authors contend this type of criteria says very little about the quality of practice or what is good or meaningful about the practice. Making judgements about the quality of practice means making value judgements, and these value judgements then become the standards of judgement.

This notion of value is at the core of what the collective aims of this PAR inquiry suggest. That is, mobilising action through stakeholders to develop a service and improve the lives of those experiencing dual diagnosis, or '*moving in a direction*' of what we collectively '*consider to be good'*. If, for example, the values of democracy, justice and empowerment are reflected in the inquiry, then these values can be used as the standards by which judgements can be made about the practice development and about any theory, knowledge claims made, and emergent from the data. These ontological commitments become what Whitehead and McNiff (2006) refer to as ontological standards. As the Cycle chapters individually illustrate the standards in terms of what it means to know, these values become epistemological standards. Consequently, as these standards have emerged from the lived realities of stakeholders' lives, they become the living critical standards of judgement by which quality can be authentically assessed.

To further support this perspective relative to methodological rigour, Reason and Bradbury (2008) note:

> *'We also want to contribute to the development of new thinking about validity and quality in research, to show that good knowledge rests on collaborative relationships, on a wide variety of ways of knowing, and an understanding of value and purpose, as well as more traditional forms of intellectual and empirical rigour'* (p.8).

Limitations

Though many of the advantages and strengths of PAR have been highlighted above, aspects of this methodological approach may adversely affect the efficacy of the research from organised and academic perspectives. Because of PAR's collaborative and participatory philosophy, engagement and disengagement, as highlighted above, remained an ongoing concern. This uncertainty throughout the process brought with it a particular dynamic of precariousness which, though intangible, many stakeholders agreed was present. As lead researcher I experienced this as unpredictable and chaotic, an unwelcome entity which I had no control over. Alternative methodological approaches may not be limited in this way, where researchers have some control and can provide some guidance over the direction of the research process, and may have more certainty about completing the research or indeed the dissertation.

The Cycle chapters individually describe further limitations as they emerged.

CHAPTER FIVE: RESEARCH CYCLE ONE – ENGAGING STAKEHOLDERS IN A REFLECTIVE PROCESS TO ENACT AGREED SERVICE DEVELOPMENTS

This chapter is the first Cycle of transformation in the inquiry and will lead into the subsequent two Cycles of inquiry. The Cycle is written and described in chronological form where possible, within PAR's cyclical, methodological structure, which mobilised service developments in the Cycle. Presenting the narrative in this format, aims to illustrate the events and processes which have taken place over an eighteen month period, approximately. While presenting the story of what happened in the Cycle within this cyclical framework, I provide theoretical insights along the way, as examples of my thinking on the theoretical and philosophical interpretation of the inquiry process. This write-up also illustrates how stakeholders engaged in on-going data collection and analysis, with this format continuing in the subsequent Cycles of inquiry.

The Cycle began with initial stakeholder engagement including HSE service-users and HSE personnel, who had collectively agreed to participate in the methodological process, aiming towards developing a new dual diagnosis service. The initiation of the inquiry greatly benefited from stakeholders already being in situ. For example, service-users were attending our collective hospital and community based services seeking help for both their mental health and addiction issues, while the organisation's multi-disciplinary personnel were delivering varying levels of care to these and other service-users also in these locations. Although in the particular context of dual diagnosis, the delivery of care prior to Cycle One was uncoordinated and fragmented (Connolly et al. 2010, 2015).

Cycle One included the introduction of a variety of data collection methods, whereby stakeholders' could clearly identify, discuss and reflect on what exactly they wanted to have included in a new service. The generation, collation and analysis of data was loosely planned for at the beginning of the Cycle, though many changes were made to these processes in accordance to mutually agreed decisions as the Cycle evolved. Considering PAR's broad

possibilities, the specific stakeholder context of Cycle One and the objectives of the inquiry, multiple data sources were proposed including: focus groups, semi-structured interviews, ad-hoc discussion meetings, participant observation and the use of daily journaling. This chapter illustrates the methods of inquiry employed in Cycle One, including what planned methods which initially seemed appropriate, and were not ultimately used, and those that worked well. Where applicable, I include verbatim excerpts from the data analysis to give voice to core stakeholders and to demonstrate:

(a) collective decision-making concerning the appropriateness of methods chosen

(b) the particular elements of the data which started to shape the new service, and

(c) to highlight the efficacy of those particular methods employed.

Core research group

At the beginning of the Cycle a '*core research group*' was formed. That title remained throughout the inquiry, despite suggestions to change it to either 'the implementation group' or 'the reflective dialogue group'. All stakeholders were invited to participate in the core research group at the beginning of Cycle One, with this open invitation being continually updated throughout this and subsequent Cycles. The method of invitation was an A4 size poster placed in appropriate locations, outlining the aims and objectives of the inquiry, and contact phone numbers of relevant stakeholders. Consensus from initial discussions suggested that the core research group would ideally include at least two service-users and one representative from each of the participating disciplines, for at least a three month period. Stakeholders agreed that considering workloads, schedules and availability, that all participants may not be able to attend all planned meetings, though in order to bridge this potential gap, the facilitator agreed to email the recorded minutes of each meeting to all core research group members. Figure 4 below illustrates the cyclical processes of '*reflecting, planning, acting and observing'*, which formed the basis for the re-contextualising of Lewin's original model that mobilised contemporary service developments in this setting.

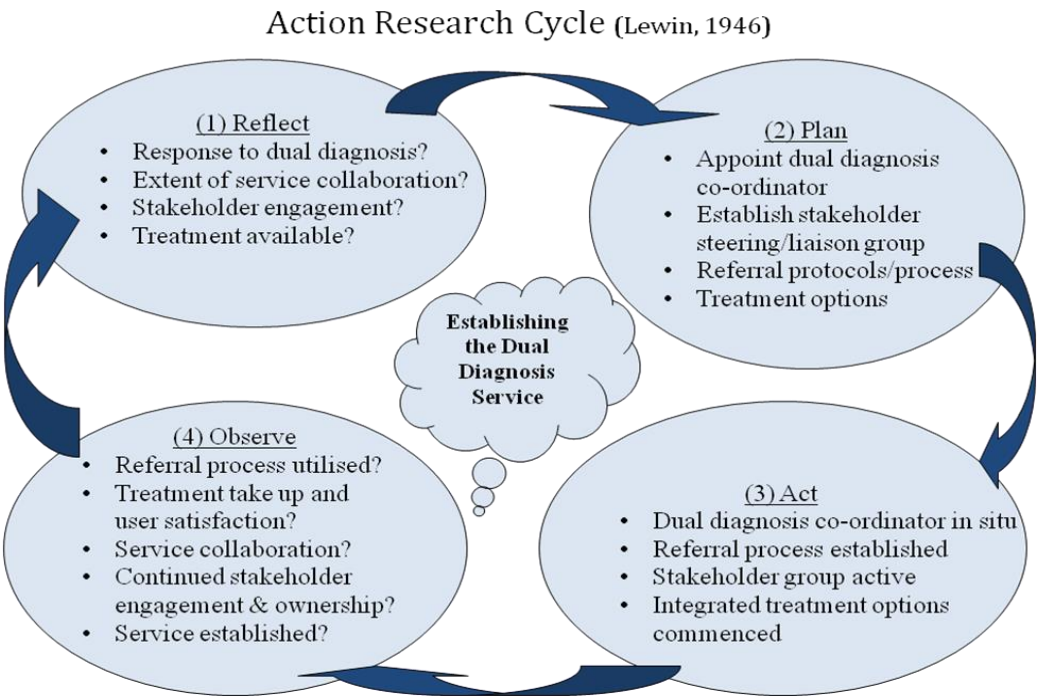

Figure 4. Action Research Cycle

This chosen methodological framework has enabled the praxis of multiple stakeholder participation, and consequently has elicited diverse ways of knowing through these Cycles of inquiry, building capacity for further service development, while contributing to the flourishing of these people in their own communities (Reason, 2009).

Reflection Phase

The context

Prior to Cycle One, and being employed within the environment of primary care, I started attending the mental health service's clinical team meetings and multidisciplinary primary care team meetings relevant to my organisational role. In the context of dual diagnosis, I proposed working in a collaborative-integrated way, rather than continuing to receive referrals remotely, as was generally the case. (Of note, at that time, there were no plans for a specific dual diagnosis service). There was general agreement that the collaborative approach made sense with many approving such proposals. Referrals to specialist addiction services from the mental health services were traditionally expedited remotely, with no system in place to follow-up on those referrals.

What stimulated this collaborative-working discussion further was the co-location of mental health and primary care addiction services in the community. For example, one mental health nurse (who was now based in the community centre, 5 days weekly), and I (also based in the community centre, 1.5 days weekly), began to discuss our respective (dual diagnosis) work practices and processes of referral. Service-users contributed narratives which exhibited benefits from the ad-hoc though effective responses to dual diagnosis that we were providing at that time. Because of these evidential benefits for clients from some integrated service improvements at that stage, and the willingness of some HSE personnel to aim towards an integrated approach to assessment and treatment, there was general consensus that a specific dual diagnosis service may be possible. Observing the informal discussions over that time about the possibility of integrating professional services across multiple disciplines and across different HSE sectors, such discussions centred on the necessity of developing new and more effective referral pathways for clients experiencing dual diagnosis.

In this context and with the broad possibility of dual diagnosis service development, Connolly et al. (2010) identified the following recommendations:

- *Dual diagnosis policy and procedure development including clinical governance while developing a quality service.*
- *The implementation of a steering group incorporating a mixture of disciplines with the objective of sharing knowledge, skills and experience.*
- *Application for specific funding to develop services and facilitate service sustainability.*
- *Form a research group to support evidence based practice.*
- *The development of assessment, referrals and treatment protocols would help define clinical practice.*
- *Mental health and addiction professionals ought to be up-skilled and integrated into a dual diagnosis response team which would evolve over time.*
- *Of particular importance service-users must participate and express their opinions in the development of services* (p.32).

As described above, many '*pre-step*' (Lewin, 1946/1997) factors within the organisational setting allowed for the possibility of developing a contemporary dual diagnosis service. Participants representing various disciplines at that time identified that such a project would

potentially involve organisational transformation. It was from discussions over that time (2009 to 2011 approximately), that preliminary talks occurred about selecting an appropriate methodology in order to bring about this planned change.

Despite stakeholder familiarity and all the physical components in place, initial attempts at forming the core research group were challenging. In the first six months of the inquiry (from September 2012 to March 2013), some stakeholders (organisational employees in particular) believed that this research was a study I (alone) was conducting, that it was some type of a research project that I (alone) was doing in the workplace and had something to do with me (alone) wanting to develop a dual diagnosis service. Despite introducing regular discussions about PAR's methodology, especially in terms of participation with core research group participants, this view about the research approach took some time to change. Albeit minimally, elements of that view remained for some throughout the inquiry, while individuals resisted participation. Much of the resistance was represented by examples of silence, avoidance and non-participation in any discussion on either the inquiry or on the subject of dual diagnosis. I encountered this resistance in informal one to one chats, at formal clinical-team meetings and informally in hospital corridors, staff rooms and canteens. Resistance to change in organisational settings is well documented in terms of how individuals within organisations and organisations in themselves (politically, philosophically and symbolically) can be resistant to change, and that such resistance can be a natural reaction to change (Mullins, 2007; Marquis and Huston, 2009, 2010; Cameron and Green, 2010; Stonehouse, 2011; Romero, 2012; Stonehouse, 2012).

Theoretical insight: The culture within this organisational context may be indicative of how change is responded to and how change may be resolved if the culture facilitates or embraces change, or not. As collaborating participants within this inquiry and specifically within the *core research group* forum, although we (mainly representatives from mental health nursing, psychiatry, social work, occupational therapy and addiction) had collectively agreed to engage in a process of organisational change, and despite this agreed-upon objective, resistance to such change still emerged within this stakeholder context.
Multiple factors may be applied to reasoning why this resistance emerged (e.g. fear of losing power, and fear of the perceived changes), and how it is to be overcome (if it can be) in order to proceed. As far as I was concerned this was unexpected, though if I ignored what was going on, it may not have otherwise been dealt with, and it may have only festered and impeded other participant's engagement as the inquiry developed.
This initial experience of resistance highlighted my role as an active change agent positioned to facilitate/communicate needs and concerns between relevant stakeholders, and also one of perseverance, with a view to working through (rather than avoiding) this

resistance. Although what facilitated the possibility of navigating through this was our over-arching change agent, PAR. Engaging us in an ongoing communicative process, whereby the resistance was explored directly within the engaging-participatory process, especially within the core research group forum. Even though inherently challenging at personal, professional relationship levels, our core research group meetings facilitated transparent discussion between participants leading towards the understanding of and resolution to some aspects of the resistance to change. While at the same time, it was interesting to observe the fluctuation and shift from resistance, where participants perceived ownership changed from being *my* research/service development to being *our* research/service development.

In team meetings, stakeholders were invited to participate in the core research group. I individually approached those discipline representatives who were more closely working with service-users. To the wider team(s) I planned for discussion of active participation in the core research group at the end of clinical team meetings, inviting all to participate.

At most clinical team meetings over the Cycle, I reiterated the importance of the service-users voice being central to the shaping of this new service development. However, over the course of Cycle One, there was little evidence that many staff members had passed on that message to service-users, which in itself could also have been construed as active/passive demonstrations of resistance to change. When this was discussed at one reflection meeting, one staff member said she was '*too busy to even think about it*', while another said '*I don't get this, what do you mean service-users participating in developing our services?*'

Theoretical insight: Such responses from staff was a concern in terms of facilitating real active participation of service-users, which are one of our core stakeholder groups. On reflection these types of responses seemed to signify (a) the early stages of the first Cycle of inquiry, which may include normal reactions to organisational change (b) the general stakeholder lack of knowledge and experience of the tenets of participatory action research, as it would be disingenuous to assume that some brief introductory discussions on PAR within the core research group forum at this stage, would equip participants with such necessary skills, and (c) that staff were over-worked and/or stressed in other areas of the service, and/or in their personal lives, which could have a knock-on effect on their attitude and engagement with this systemic change.

Though concerning our core stakeholder group and as discussed in the Methodology chapter above, one objective in choosing PAR was to aim towards what Freire (1972) discussed in the *Pedagogy of the Oppressed*, that when people are particularly disenfranchised (such as this group experiencing serious mental illness, addiction and social exclusion issues), it may require greater effort to assist these participants towards empowering themselves, and in particular through the medium of dialogue. Fortunately in this regard, PAR's methodological approaches have created a forum which gives an active voice to those who

may previously have had the least voice in their day to day living, even while attending professional mental health services.

Enhancing stakeholder engagement

The reflections above informed the initial process of stakeholder engagement whereby many stakeholders initially engaging in the collective services were familiar with one another, and with the geographical environment and buildings where the inquiry took place. This ensured that a genuine participative process could be facilitated with these stakeholders in the beginning of the inquiry. Initial stakeholders included: service-users and family members, two consultant psychiatrists, one psychologist, mental health nurses, one occupational therapist, one psychotherapist, one clinical nurse specialist, one acupuncturist, one addiction counsellor, two art therapists and one mental health social worker. Disciplines represented at this time included mental health, psychiatry, addiction, psychology, social work, occupational therapy, general practice and academia.

Once ethical approval was granted from the Cork Teaching Hospital Ethics Committee, this provided the impetus to drive the service development and stimulated the initial discussion groups about how informed consent was to be delivered on a case by case basis. In this regard, discussions on the ethical issue of informed consent took place with all stakeholders, with approval sought from line management and consultant-psychiatrists on both participating mental health teams. As part of the ethical approval process, stakeholders agreed that informed consent was to be obtained from service-users on referral into the service and after they had received a full description of the inquiry, with this also being updated if service-users re-entered the service, if they had disengaged. Similarly, informed consent was given by all other participants as they entered or re-entered the inquiry/service development context.

An invitation poster was placed in relevant organisational locations to facilitate participation, while the annual CRSI conference in the School of Nursing, University College Cork was the venue selected to officially launch the inquiry. As part of the recruitment process, I collated some introductory explanations of PAR and emailed same to potential participants. From this, and further discussions eight stakeholders (six staff members and two service-users) formed the initial group. From the start the agreed understanding we had with service-users engaged at that time was that their participation was on their terms, which meant they could come and

go from the research group as they pleased, though in a planned, scheduled fashion where possible.

Reflections on cyclical processes

Cycle One was an ever-moving, evolutionary and participatory process (Koshy et al. 2011). Reflecting on this Cycle epistemologically, it is encouraging to participate in a process which facilitates stakeholders in the creation of knowledge, which is based on our collective context-specific experience. In Cycle One this has occurred through regular critical reflection on that experience, constructing abstract generalisations from that reflective process, testing decisions made within this setting and ultimately gaining new knowledge and experience.

All of these processes took place within the social realm, how we negotiated meaning through dialogue with critical friends, my research supervisor and colleagues, all contributing unique perspectives within a collective sense of mutual trust and respect as equal partners in the participatory process. As Cycle One was beginning and all dynamics were in flux, it was challenging for me to identify what particular theories or philosophies were informing the Cycle as it was in constant movement. The reflection process however, has helped identify which theoretical frameworks have contributed to this process of inquiry so far, which are briefly introduced here.

The philosophy research methodology of *Phenomenology* informs the inquiry at many levels where various aspects of phenomena related to dual diagnosis are explored, inquiring how we subjectively understand such varied concepts and models.

The qualitative data generated and analysed in Cycle One has been conducted with the objective of elucidating meaning, where understanding can be gained (from data) which can contribute to empirical knowledge or an emerging theory.

> '*Interpretation is a clarification of meaning. Understanding is the process of interpreting, knowing, and comprehending the meaning that is felt, intended, and expressed by another*'
>
> Denzin (1989, p.120).

While having distinctive conceptual differences in terms of the overall methodological and philosophical approaches, aspects of the data analysis process in this Cycle, have reflected that of a *grounded theory* methodology (Corbin and Strauss, 2013), particularly in how the

data were categorised and coded, in how the themes emerged, and in how the findings were created from that data.

This Cycle was a constantly moving process, as participants learn and work together, collectively informing the next step based on processes of reflection, which draws from the theoretical framework of *living theory* (Whitehead, 1989, 2006); while from an *organisational development* perspective, it has been conceptually and theoretically aligned with the broad realms of action research for many decades (Habermas, 1971; Greenwood and Levin, 2006). Being increasingly aware of the myriad dynamics which inevitably take place within the constructs of an organisational structure such as that in Cycle One, this leads the researcher to a philosophical/theoretical position whereby such dynamics need to be carefully negotiated. Although many positive attributes concerning general engagement and initial service developments are illustrated below, many of the more challenging aspects of human behaviour including power and control, emerged as potential obstacles during the Cycle. In this, we can draw from elements of both *critical theory* and *appreciative inquiry* as theoretical frameworks which may inform our negotiations with both core and peripheral stakeholders/agencies, so as not to impede on mutually agreed progress, change and improved development (Habermas, 1978; Cooperrider et al. 2008; Corbin and Strauss, 2013; Kemmis et al. 2014).

Planning Phase

This section illustrates the highlighted actions planned for, which were gleaned from the data gathered over that time, from journals, field notes, diaries and core research group records. In planning the writing of this Cycle, I selected the predominant planning components pertinent to this phase of the inquiry, with highlighted percepts of the proposed service developments beginning to emerge as the Cycle unfolded. The writing format aims to portray the collective story of what happened in the Cycle, while simultaneously identifying the subjectivity of my own methodological, theoretical position, within the inquiry (Bradbury-Huang, 2010; Levin, 2012, pp.143-146). Figure 5 below illustrates the actions which were planned for in this Cycle, and are discussed below.

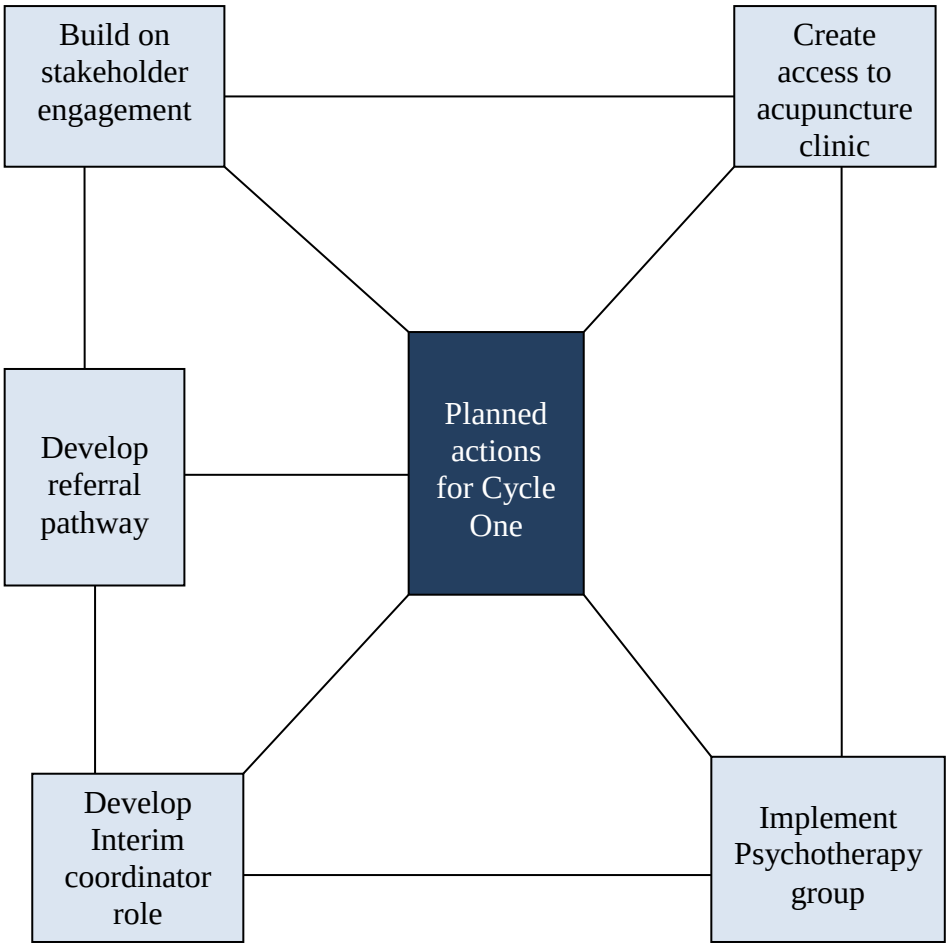

Figure 5. Actions/service developments planned for in Cycle One

Theoretical insight: Being a central participant in the Cycle, it was challenging at times to orient myself in the developing process, to separate the wood from the trees so to speak, theoretically and practically. For example, while facilitating and simultaneously participating in the varied methodological processes (particularly planning) related to this new service development, and also conducting my normal duties from day to day on site, I found it helpful to map the processes visually as I proceeded. I did this by talking, questioning (with critical friends and other stakeholders) and drawing (sketches in my journals etc.), in an attempt to illustrate and engage with the unfolding process from a sense-making perspective, and likewise in the write-up of the Cycle. This expression of sensory interpretations of what I was encountering in this phase of the inquiry, contributed to my developing awareness of percepts emerging which were relative both to the aim and objectives of the inquiry in general, and specifically to these plans for Cycle One.

Data collection plans

Plans for data gathering in this Cycle included the following stakeholder group sources: the core research group, the psychotherapy group and the multi-disciplinary team (MDT) group. Data gathered in log-books, folders and notes taken in these groups over the Cycle, were planned for data collection. Participants' field notes and participant observation data were also planned for in this Cycle of inquiry.

The planning of actions for Cycle One highlighted in Figure 5 above are described below.

Stakeholder engagement

The core research group also decided at this planning stage that where possible, any decisions were to be made in the group context ideally, though if in-between planned meetings were required, at least two stakeholders would communicate prior to any further actions taking place. Participants agreed that any informal or non-scheduled meetings which would inevitably occur, would be logged individually in diaries/notebooks by those participants and the data fed back to the relevant planning and/or reflection meeting. The general purpose and function of the core research group was also discussed by participants at this stage. I proposed that I would initially facilitate the meeting(s), though in accordance with PAR's principles, participants agreed that the facilitator role would rotate.

Upon discussing PAR's theoretical components with the research group on an ongoing though ad-hoc basis, we agreed that the objectives of this forum would include (a) strategically plan decisions for both Cycle One and further Cycles (b) accommodate the process of critical reflection on actions which had been planned for, and (c) act as a collaborative-dialogic method for further development of the inquiry process. Central to achieving these objectives was collaborative discussion and agreement on which data collection methods were to be selected as appropriate to particular planned actions for the Cycle, and the ongoing processes of data analysis which would continue to inform decisions throughout the Cycle. This forum was agreed as another context for data analysis, as planning and reflective processes would also consistently inform that group process. This enabled the multiple cyclical processes occurring simultaneously to feed into the ongoing process of data analysis, which in turn informed the next decisions and actions to be implemented. However, it was also agreed that planning data collection sources including specific focus groups and interviews may be appropriate methods for exploring certain topics and critical aspects of the service going

forward. Further stages of analysis could thereafter be conducted by the focus group members and also within the core research group forum, '*the essence of research is to produce new knowledge applying accepted scientific methods*'. Levin (2012, p.137).

Apart from the larger core research group forum, where stakeholders met in a planned way every four to six weeks over the Cycle, smaller and less formal and ad-hoc planning meetings/sessions and discussions also occurred throughout Cycle One. Initial planning meetings were focused on immediate service development concerns that stakeholders had been discussing for some time. Although these actions took place in Cycle One, decisions to implement these actions occurred in the early planning phase of the Cycle. These were discussed by the research group and prioritised in terms of their perceived immediacy, with the coordinating role relative to service integration and the implementation of group-work for service-users taking priority.

Coordinating role

Having previously assumed another coordinating role within my primary care addiction counselling post, it was a natural transition for me to take on this necessary temporary coordinator function. This was in order to facilitate collaboration, and methodologically, to lead communication processes and actions within this Cycle of inquiry. Planning this interim position which thereafter was approved by line management, initial tasks were to include the streamlining of referrals and to liaise between service-users and multidisciplinary team members. We agreed that these tasks would be reviewed monthly and feedback to the research group on this development.

Coordinating care on behalf of service-users was identified as a priority in Cycle One and had been previously discussed by stakeholders. However, for the majority of participating stakeholders, the coordinating role was perceived as being directly linked to the planning and implementation of a referral pathway for people experiencing dual diagnosis. On a day to day basis, as interim coordinator, it was decided that I would manage the (dual diagnosis) referrals and initially in an informal capacity, though the process of developing a formal referral pathway was to be planned for initially within the core research group forum. On this basis, it was agreed that a referral protocol template would be developed, and that individuals would individually consider over the following weeks/months what particular components were necessary to be included in this document. No specific tasks nor time-limits for this were

agreed or given to any individuals. Though it was suggested that participants continue to engage in the journaling method of data collection, for example, documenting any thoughts, ideas or insights concerning this referral process, with the objective of reflecting on this data in the core research group.

Theoretical insight: On reflection this laissez-faire approach was not ideal, as it led to indecision and procrastination, where everyone appeared to get on with their normal work routines and nothing meaningful, in terms of note taking or introspection was gathered concerning this protocol development after initial planning meetings. However, despite such apparent inaction, I felt it was positive step that the core research group was beginning to retain participants and I didn't want to jeopardise this by focusing discussion on what participants appeared to be not doing. In hindsight, this represented both my own fears of sitting into this new coordinating role and the possibility of stakeholder disengagement, which subsequently materialised to be unfounded when the issue was ultimately discussed by the group.

'*Using PAR, qualitative features of an individual's feelings, views and patterns are revealed without control or manipulation from the researcher*' (MacDonald, 2012, p.38). Albeit within an educational context, Schon (1983) also encourages practitioners to make reflective practice explicit by sharing such context relevant thoughts and feelings with other participants for purposes of transparency within the research process.

Referral pathway

Stakeholders decided that when the referral protocol was completed by the core research group, that it would be put in place as a working draft document, while awaiting final management approval. The timeline set for the final draft document of this referral pathway protocol was to be completed during Cycle Two. Tentative, though documented, preliminary plans for Cycle Two included the implementation of this working document in inquiry locations, including the acute hospital ward, clinical nurse specialist's (CNS) office in the *A & E department* of the same hospital (CUH), the community centre, other relevant HSE buildings locally and with agencies who may be potentially referring into the service, for example, GP practices who were currently referring to our collective services.

At this stage in the Cycle, the components of this action planned for included: an agreement from the core research group that upon receipt of referral, I would conduct an initial assessment, take responsibility for engaging the service-user with treatment options available. Participants also recommended that for the foreseeable future those referred would maintain

engagement with their clinical teams until it was decided otherwise. Ultimately, in terms of service planning, this set the scene for the implementation of collaborative working practices, which were previously fragmented with individual practitioners working in un-coordinated and isolated ways (Connolly et al. 2010). From the outset in the Cycle, it was clearly highlighted in the research group that implementing an integrated dual diagnosis service required an effective referral pathway, which would be planned for in accordance to all stakeholders needs. Importantly, such plans included the process of implementation being subject to rigorous methods of inquiry, including: ongoing stakeholder observation, and participating in individual and collective critical reflection processes. These reflections in turn, would evaluate the actions as they happened, and subsequently informing further steps of the referral pathway development process.

With the objective of continued planning of the referral pathway, stakeholders agreed that the core research group forum was the most appropriate source for the monitoring of this development. Stakeholders also agreed that the choice of data collection methods would continue to be decided by core stakeholders, with particular consideration given to all service-users, enabling their collective voice to actively contribute to decision-making concerning this and other planned actions.

Psychotherapy group

Having been explored generally at preliminary core research group meetings, group therapy work for service-users referred to the evolving dual diagnosis service was strategically planned for early in this phase of the Cycle. The background to this was the realisation from stakeholder discussion that all individuals experiencing dual diagnosis were attending hospital and community services and seeing professionals in an individual capacity, only. Some participants (organisational employees) having had clinical experience in other working environments proposed the notion that service-users may benefit from meeting in a group capacity. As this overall inquiry was planned on the basis that all stakeholders have an active voice in planning, implementing and evaluating all aspects of service development, core participants (service-users) were included in planning this action, whereby each person already engaged with our services was asked if they wished to participate in such a group if it were to be implemented. Numerically, those who were in favour of such were initially in the minority, with over 50% stating their reluctance to group participation. This was not

surprising, as many people experiencing dual diagnosis are often resistant to various types of group work for many reasons, not least isolation (Menezes et al. 1996).

Stakeholders generally agreed that services were to be developed in accordance with all participants needs, and that any newly introduced actions could not be imposed on people. In this, the group would be provided for those who wished to attend and that its structure would evolve as the Cycle developed. Based on participants' collective experiences of group work, the core research group agreed that implementing this would be an appropriate action. Stakeholders also agreed that the group was potentially a rich source of data, from which all participants could participate in and could be collected on a weekly basis.

Having a base in the community centre and while service-users had previously declared a preference for accessing services there rather than in hospital settings, the research group agreed that one participant would approach the appropriate HSE personnel to include another room in its contract with the community centre.

Access to acupuncture

Access to the acupuncture clinic was planned for and quickly enabled in Cycle One, with this being an additional resource for service-users who did not have access to this service prior to the commencement of the Cycle. As the acupuncture clinic had previously operated in a non-residential addiction treatment setting in another hospital in Cork city, service-users experiencing dual diagnosis would not have had direct access to or previously attended that service. Early in Cycle One, two stakeholder groups (the core research group and the MDT group) began to discuss the potential benefits of acupuncture for dual diagnosis service-users. It was suggested that the notion be discussed with the third group, the psychotherapy group. There was mixed reaction to this proposal, with the information (predominantly data emerging from the psychotherapy group) suggesting that participants were both sceptical of its potential benefits and also some being fearful of the thought of needles being put in varied places around their body. Despite some initial apprehension, the general consensus ultimately from all three groups was an expressed desire to seek access to the acupuncture clinic which was being currently delivered in another hospital location (about 4 miles from the community centre, about 15 minute drive, and on a bus route).

Communication processes

Providing an overview of communication processes between stakeholders, the planning meetings that took place over the Cycle included many subjects/proposals identified as being relevant to this phase of the development. These were placed on the planning agenda for further discussion as the Cycle evolved, or if it were agreed as not being relevant to this Cycle, proposals were placed on the agenda for Cycle Two. Some of these subjects included: dual diagnosis assessment tools; mindfulness; tai-chi; acupuncture; data collection, national lottery application, service-user participation and ethical considerations.

Planning meetings in the Cycle almost always occurred as they had been previously planned for, though frequently not all participants attended, with on the day work constraints, annual leave and sick leave also affecting participation. Overall though, inter-participant communication was active and robust, with elements of confidence, trust and familiarity within the process evident in participants' interaction, which appeared to be developing as the Cycle unfolded. The planning meetings in Cycle One started with a *review* of the previous meeting, followed by a discussion on current business or *action*-planning, followed by further *observations*-discussion from that, and finally a *reflective*-concluding discussion on targets aimed for until the next planned meeting.

Although engagement in the core research group was generally developing positively, service-user attendance and participation in this process fluctuated during the Cycle. There may have been many reasons for this, though some people disclosed complications or concerns in their personal lives as reasons for non-attendance rather than anything to do with the service development in general or any resistance to the core research group process itself. In as much as was realistic, I repeatedly reiterated invitations to all stakeholder groups to participate in this as the inquiry developed.

In terms of an effective communication framework, the predetermined activities at many pivotal junctures throughout the Cycle were advertised using hard-copy A4 size notices and placed on various notice boards in many buildings as described above, the bulk of communication between stakeholders that have email addresses was conducted in this way, or for those without email access, it was verbal face to face and/or telephone communication. This method of communication by email was agreed in planning meetings early in the Cycle, as it was the most practical option, considering the constant movement of staff (particularly)

going from one hospital and/or community centre or HSE building to another. I agreed to take responsibility in Cycle One for the dissemination of principle communication necessities to stakeholders and for those where email was not available/suitable, the information would be given verbally in person or by phone.

Theoretical insight: Even though it was evident that an element of trust was forming within the core research group forum in particular, in terms of how participants were communicating with each other, I suspected that some participants (service-users) may have felt they lacked capacity to fully participate in discussion at times, in comparison to others (organisational employees) who have more experience at articulating aspects of the subject discussed. While active participation of this core stakeholder group is one of hallmarks of PAR, and though their participation to date in this Cycle is remarkable, I wonder if this stakeholder group's capacity (in terms of communication and articulation) can be developed so that their active participation can be increased, or if this notion of *stakeholder capacity* is to be ignored, will their participation be compromised as the inquiry develops? For example, without explanation will some service-users disengage from the core research group because of feeling incapable of actively participating in all discussions, and if this is probable, how can this be reduced or eliminated in the inquiry?

In relation to HSE buildings and locations used during the inquiry for communication and service development purposes, the core research group decided that Togher community centre was the most appropriate building to use, both for the majority of stakeholder meetings and for the storage of hard-copy information and data pertinent to the inquiry. As described above, the HSE on behalf of both the mental health services and the primary care addiction services in this sector, already had space rented in this building, and as above many core stakeholders had previously identified their preference of engaging with HSE staff in the community centre rather than other public locations, including hospital buildings and other designated mental health service buildings. This factor and the fact that service-users from this geographical area attend mental health service's 'out-patient clinics' in the community centre and staff team meetings also occur here, contributed to the decision that this location would be the principle hub for the inquiry. Communication data marked '*Cycle One*' form all three data sets was stored on computer hard-drives and files in a filing cabinet in this community centre, as well as on my laptop and work phone.

The general nature of community based mental health and addiction services, allows users of such services to engage, maintain engagement, disengage and re-engage with many of the disciplines provided by these collective services. In this, the environment where this inquiry

took place was no different. As this research inquiry was an ongoing process commencing with Cycle One, it was critical that a mechanism was planned for, whereby stakeholders would be continually informed of the inquiry process as they entered or re-entered services, and in particular that consent was obtained regarding inquiry/service development participation. Following discussion and agreement from management, the informed consent form (Appendix B) was designed by the core research group, and outlined the inquiry's aim and objectives and an option for participants to agree or not to participate in the process. The informed consent form was placed in all service-user files on initial engagement and re-signed on re-engagement with any of the disciplines participating in the inquiry/service development in the community. Likewise, other participants/stakeholders were invited to sign consent on entry/re-entry to the inquiry context.

Discussing the inquiry's aim and objectives and requesting an informed consent signature, though critical, was an additional and previously unknown task for some staff/participants. So that all staff would discuss with service-users, the importance of informed consent as an ongoing process (see *Rolling Consent Form*, Appendix F.), it was agreed in a planning meeting early in Cycle One that this matter would be highlighted briefly at the end of each weekly team meeting and emphasised in particular when new staff members joined the team(s). Both a CNM2 and I agreed to share responsibility of these processes for three months and then review.

In the event of a service-user wishing not to participate and/or not sign the consent form, it was agreed that the necessary participating stakeholders be informed by highlighting this clearly in writing on the persons file and/or if appropriate also verbally. In this, and considering all planning processes for the inquiry, stakeholders agreed that open and transparent communication was to be a guiding principle to maintain throughout the planning and following cyclical processes of the inquiry.

Theoretical insight: During the planning phase of the cycle, some stakeholders (organisational employees) informally discussed challenging times in their personal and professional lives resulting from the economic recession, salary cuts and challenging working practices. This they say (in canteens, staff rooms, etc.) impacts on their work morale in general. (Much of this sense of 'low morale' appears to be largely unsaid in the workplace, though seemingly very much there in consciousness, for example the media and current affairs topics are dominated by negative-recessionary discussions, adversely affecting public service employees/many stakeholders in this inquiry). Observing this from

day to day, this collective negative energy may influence one's motivation towards fully engaging in a process, which at this planning stage seemed to be perceived as 'my research project', i.e. that this is a piece of research that John is doing, rather than a participatory process, which includes all who wish to be involved. To facilitate and lead on-going engagement in this process, I believe I need to be sensitive to all these potentially contributing factors.

Conversely, one participant (consultant psychiatrist) expressed particular support for this service development early in this Cycle by being quite motivational in her public expressions (at team meetings and at a university based conference) of supporting the collaborative approach necessary to bring these aim and objectives to fruition. For some stakeholders, this appeared to be encouraging amidst some apparent resistance within teams at this time. Realising this was my initial insight in this regard in the Cycle of the necessity to work more consciously and in a more focused way with those whom embraced the aim of the research question, hoping that others may follow by example rather than by any means of coercion. In this, and in terms of clear communication with and on-going sustainable engagement of stakeholders, my learning experience from this phase of this Cycle suggests that an active and open approach blends well with the chosen philosophical guidance of pragmatism, where the beliefs and experiences of participants in this real life setting are actively shaping the actions/service developments continually being planned for.

Action phase

The actions/significant service developments which were implemented at this time were the interim-coordinating role, the psychotherapy group and access to the acupuncture clinic. These actions are presented below, following the introduction to this phase of the Cycle.

Where one component of the Cycle has often merged into another, for purposes of clarity this section includes:

- The significant actions which have commenced.
- How decisions were made to bring about these developments.
- What the implementation processes were like, and
- How these were evaluated/reflected upon.

This section also demonstrates how stakeholders have worked together through action and reflection that led to the decisions made in the Cycle. As this inquiry brought together people who work in and use this area of HSE public health services, many levels of engagement have facilitated the development of knowledge from 'on-site' experience by giving participants equal voice, which in turn contributed to the shaping of the evolving service.

Referrals

As the Cycle got under way and focus remained on developing a referral pathway, referrals continued to come from GP's in primary care, community mental health teams and other addiction services. The more I was integrating with the two mental health teams, the more dual diagnosis referrals were coming to me from the acute unit in the hospital (CUH). In effect, dual diagnosis referrals began to dominate my case-load as word about the developing service was spreading across the sector. As the referral process was developing informally, I repeatedly fed this related information (stored data by daily journaling) back to the regular core research group meetings in the context of the necessity to develop a referral pathway protocol.

Role flexibility

Participants also highlighted that the roles which nurses and other stakeholders held, prohibited them from taking on other tasks or roles outside of their normal duties. Participants identified the organisational system as having little flexibility in terms of role diversity, particularly concerning the implementation of new initiatives. One example included nurses working in one sector delivering services under the direction of a consultant/team, were restricted to that sector/geographical area. As service-users were now being referred into the evolving dual diagnosis service, the constraints of the 'sector only system' prohibited personnel from working with services-users from sectors, other than the one within which they were employed. This systemic inflexibility inevitably excluded some service-users and was highlighted in the core research group process as an element to explore later in the Cycle or in Cycle Two.

Data gathered

From planning meeting discussions and ad-hoc meetings between participants, field notes taken from within the three groups (the core research group, the MDT group and the psychotherapy group), were kept in logbooks, journals and diaries and was analysed on an ongoing basis. Data was also gathered from the method of participant observation employed by stakeholders.

Coordinator role

The evidence of my (interim) role as coordinator was proving crucial to enable the integration of services and disciplines necessary for the service-user to access at varying stages of care.

The emerging data (notes in journals, logbooks and discussion records at core research group meetings) suggested that while planning for or having a referral pathway on paper (planning this locally on our core research group table, or having access to other referral pathways in HSE policy recommendations) may sound great theoretically, a designated person(s) is necessary on the ground to physically bring about that actual integration of services/disciplines. The experience of this in Cycle One required considerable time. Although, the geographical locations of the buildings and services involved (described above), included an area of about five square miles, what was important to implement this integration was the face to face meetings and interactions with the relevant personnel. Although my face was familiar in these locations from my daily routine over previous years, in the context of this Cycle of inquiry, I was now conducting business with the particular aim and objectives of the inquiry in mind. Within this, each step or action was ideally pre-planned collaboratively (sometimes with many stakeholders, at other times with only one other stakeholder, though at other times necessarily made alone), though I was constantly observing (taking notes, journaling) all the happenings as they were occurring and reflecting on these as the Cycle developed.

Example in context

One example provided here of the early phase of a referral, highlights the physical practicality necessary in order to enable this communicative-integrated process with participating stakeholders: On receipt of the referral by email, post or phone when situated in Togher community centre. I am informed that the service-user is in the hospital's acute unit and has been hospitalised for a number of days, with a probable dual diagnosis featuring. General plans from the consultant suggest the person may be there for a further six/seven days and would benefit from a dual diagnosis intervention. I phone the unit to speak to the nurse on duty/service user's designated nurse, to confirm my intention to visit the unit and to initially engage with the person, arranging a suitable time, considering meal times, other unit activities and visiting hours. All going well and with this plan in place, I drive from the community centre to the hospital car park (20 minute drive) and make my way to the acute mental health unit. I meet with the nurse with whom I had previously spoken, discuss the details of the admission, what the consultant's notes and recommendations are, and then meet with service-user in a private meeting room. Initiating engagement with the service-user usually takes up

to an hour, thereafter I speak with the nurse again if necessary and I update the notes summarising the discussion and plan. If necessary, this step in the referral (where I deviate from my work schedule in the community and engage with the referral in the hospital), may be repeated several times prior to discharge. By the time I return to my work base in the community, this visit would usually take up to two hours. Though initially time consuming, this critical element of the referral process, where the service-user engages with a member of the dual diagnosis team while in the acute phase of the referral and who will be potentially engaging further with post-discharge in the community, is critical in order to establish real engagement at a particularly vulnerable/crisis phase. The implementation of this action emerged from early planning discussions in the Cycle, where it had been identified by stakeholders familiar with the hospital referral process, that prior to this inquiry, referrals from the acute unit to other community based services, in the specific context of dual diagnosis were largely ineffective. For example, service-users, upon hospital discharge, were verbally informed to contact specialist addiction services in the city to support their addiction/substance use concerns. Post-discharge, there is little evidence to suggest that this happened at all, though when it did, people's mental health diagnoses did not fit with the admission criteria at specialist addiction services, whereupon service-users were signposted back to the mental health services, a process which became metaphorically referred to as '*the revolving door scenario*' (Daly et al. 2010). Tragically though in terms of service provision, the service-user's experience of this was that there was no service which comprehensively responded to their needs (MacGabhann et al. 2004, pp.80-84; Phillips et al. 2010, p.5; Connolly et al. 2015, pp.34-35). In order to effectively bridge this identified gap, and based on stakeholders' ongoing experience of this ineffective service provision, the core research group planned that for the duration of Cycle One, the interim dual diagnosis coordinator would be the most appropriate individual to make this critical link.

Role duality

While implementing this role in Cycle One, I was doing so while maintaining other duties within the same geographical area where the inquiry was being undertaken, and also working in one other sector. As referred to above, the role duality experience of lead-researcher/interim coordinator in the inquiry and other functions of my main post was challenging to begin with at the start of the Cycle, particularly in terms of feeling isolated (as I had nothing to measure

it against), though which became more understandable and then more manageable as the Cycle developed. Reason and Bradbury (2008) discuss Roth's (2002) notion of managing the dynamics of role duality as being a learned-by-experience skill, which he proposes as being experienced on a continuum, where at the beginning the diverse roles are almost distinctly separate (psychologically and practically), and as the inquiry unfolds, they merge and become more manageable, though through continuous dialogue and renegotiation of roles being critical, '*the struggle to contribute to both, the ongoing conflicting agenda, and the need to continuously renegotiate with organisation managers, often leads to a sense of being an outsider in both worlds*' (p.650).

Theoretical insight: What became a particular ally throughout this process, was the method of journaling which captured many perspectives (mine and others) of what I was experiencing, what was happening in real-time and which in turn informed much of the data generation, collection and analysis processes relative to the experience of this role and observations made throughout the Cycle. In this, journaling, although an effective method of data collection throughout, became a resource much greater than that, containing benefits which I could not have previously understood, before applying it in this context. Where previously in practice I relied more on diary insertions and memory in my day to day work, the value of writing down observations, thoughts, comments and ideas of others in a focused manner became a valuable tool, particularly useful when so much is happening in real-time that can at best be challenging to grasp. Journaling as such has been as close I could get to recording all of what was consciously taking place, and which thereafter I could both reflexively consult and utilise in discussion with others.

Much is written about the methodological context and challenges of role-duality in action research (Adler and Adler, 1987; Ashforth et al. 2000; Smith and Boucher, 2003; Roth et al. 2004; Tenni; Williander and Styhre, 2006; Humphrey, 2007; Moore, 2007; Ravitch and Wirth, 2007; Reason and Bradbury, 2008, (pp.644-646), and Herr and Anderson, 2015, (pp.96-98), though it is from the doing (action) in this real-world-context of Cycle One, that the learning emerged from the data collected. The literature highlights the advantages of implementing methods such as journaling, in order to capture phenomena as it occurs, '*a system that systematically records choices and their consequences for oneself and other participants*' (Reason and Bradbury, 2008, pp.647-648). On reflection, I greatly acknowledge the support and encouragement of some of those managers/stakeholders (primary and peripheral), who by their varied interactions helped decrease that sense of isolation and '*outsider*-ness' I felt at times. In this, Coghlan and Shani (2014) highlight the importance of developing quality

relationships between researchers and members of the system being inquired into, particularly concerning the pivotal roles of research participants (p.525).

Stakeholders participating in the three groups discussed above, collected and analysed data concerning this coordinating role, examples of which are illustrated in the '*data analysis*' section below.

Psychotherapy group

The core research group agreed that the most appropriate type of group work to commence ought to have a psychotherapeutic objective, though implementing such a group significantly contrasted with that of other related services. For example, in mental health and addiction services where individual and/or group psychotherapy resources are frequently delivered, one general entry level criteria for those services includes abstinence from illicit substances and/or stabilisation of alcohol use, service protocols in this regard usually request supported evidence of three clean urine samples provided over a six to eight week period. This criteria alone would automatically exclude the majority of service-users presenting to this dual diagnosis service, where participants often continue to use substances daily and where it is frequently inappropriate to initiate discussions on modifying or stopping same. Such criteria however may be appropriate for other service providers where assessment and treatment approaches differ. Stakeholders suggested at the beginning of the Cycle that services-users attending this new group would not present under the influence of alcohol/illicit drugs on the morning of the group; in as much as is realistic considering the intricacies and diversities of drug use, this suggestion has been largely adhered to. Where this group of service-users were either excluded from or had difficulties in accessing addiction or mental health services respectively, there was evidential consensus early from the data emerging in the Cycle that many individuals wanted a forum where they could speak openly and freely and where they wanted to be heard, understood and respected. The implementation of this planned action has highlighted again how PAR's methodology has been most appropriate in this particular context, where it enables our core stakeholders to participate actively by expressing their voice, which otherwise may have not been spoken nor heard, as Reason (2006) notes:

> '*Sometimes, immediate practical outcome is what is most important…..but sometimes in action research what is most important is how we can help articulate voices that*

are not being heard. How can we draw people together in a conversation that is not taking place? How can we create space for people to articulate their world in the face of power structures that silence them?' (p.198).

Theoretical insight: Regularly participating at various levels (as facilitator and data collection note taker) within this psychotherapy group, I am mindful that my own voice and positioning in the inquiry concerning researcher's bias, emerges in this context again. As highlighted in the Introduction chapter, having subjective-personal experience of the subject (dual diagnosis), as I relate at a personal experience level with service-users in this psychotherapy group, I potentially bring this implicit bias into the field, which I must ensure does not influence or contaminate either the data collection or analysis processes. To minimise this potential inclination, Levin (2012, p.144) proposes to make this reality as explicit as is reasonable within the stakeholder group, which I did at the outset with the core research group and am open to doing so when appropriate as the inquiry unfolds. Bradbury (2010) discusses quality while conducting action research, suggesting that '*being value neutral is not a pretence action researchers uphold*' as we communicate with locals in the real world in our own community and '*using this as an opportunity for validating and disseminating local learning*' (p.99).

Acupuncture clinic

Once agreement was negotiated and agreed between hospital management, the acupuncturist and the interim-coordinator, service-users began to attend this additional service, with access to this clinic being made available four days each week. Even though it would be disingenuous to suggest otherwise, collegial familiarity was certainly an influential factor in the negotiation process of this service integration, where I had previous professional relationships with the organisational personnel concerned. Although in terms of this organisational development, an individual was certainly required in order to physically negotiate the process. Where the management of this acupuncture clinic unquestionably welcomed and opened-up access to this group, implementing this planned action demonstrated again the critical function of the dual diagnosis coordinator in building bridges between local services. Similar to this acupuncture clinic, such services may already be available, to which service-users may require access, though may not know that they exist and/or may be excluded for criteria embedded within that service. In terms of service provision and/or access acquisition, Stringer (2014) suggests that '*we must acknowledge the experiences and perspectives of those to whom programs and services are directed, rather than of those who deliver those services*.' (p.138). The process of implementing this action has highlighted how certain therapies/interventions that may be already be in existence, may be made accessible for this cohort, via the role of the

interim-coordinator. Though it was not possible to perceive this in the planning phase, implementing access to the acupuncture clinic enlightens broader possibilities of access to other existing services that there may be locally.

Theoretical insight: The application of these planned actions in the real world of people's everyday lives, means that a fluid process is continually unfolding. Within this, plans are collaboratively made though frequently need to deviate in response to the current situation, which appears to be no different to how our own lives generally unfold. In this action phase, stakeholders have expressed a voice and actively participated in service developments and in what methods of inquiry were appropriate/suitable to them. This in turn informs what further methods of inquiry will be employed, and what further services will be accessed and developed in accordance to participants' specific needs.
For the inquiry context, my coordinating role acts as a dialogic-bridge to facilitate such nuances with participants; what concerns me is when the inquiry is complete and when competing perspectives may emerge, what can be put in place within the system, so that service-users can continue to actively participate in developing their service?

Observation phase

The foreground to Cycle One is important to illustrate here, as it provides an observation of some of the contextual factors which formed the impetus for the inquiry, and also to visually illustrate some of the developments which thereafter occurred in this initial Cycle. For example, *Process map A.* below illustrates the environmental context prior to Cycle One, where dual diagnosis service-users entered the acute hospital, engaged in various mental health service activities whilst in hospital, and upon discharge were referred to either community mental health services and/or specialist addiction services, which did not respond to their complex needs in any integrated or coordinated way.

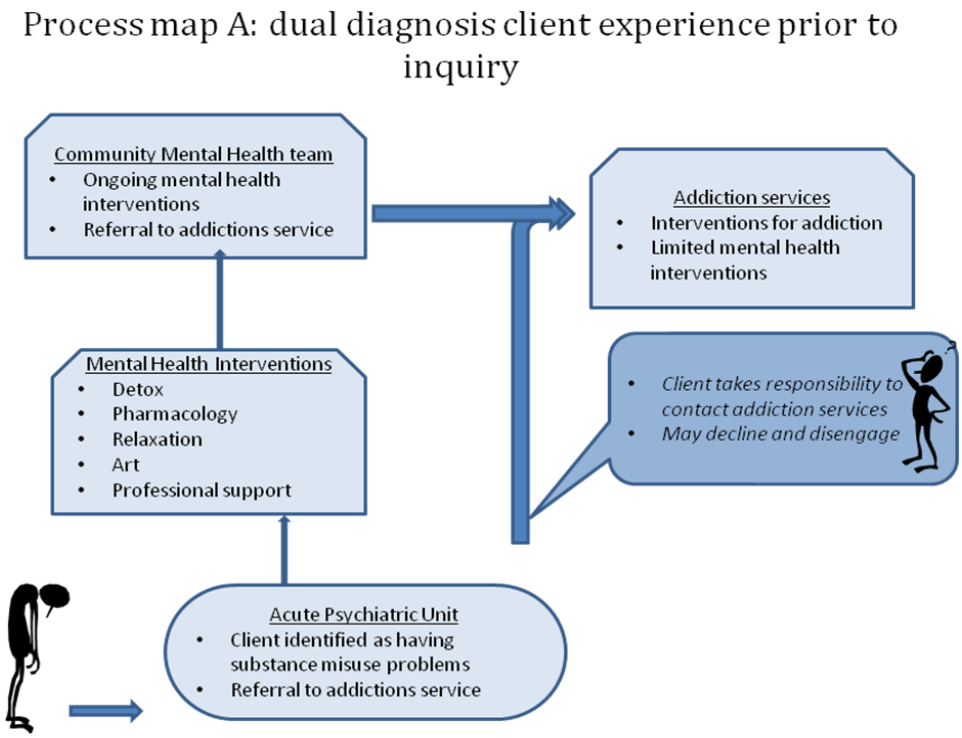

Figure 6. Process map A.

The actions/service developments discussed above in both the *Planning* and *Action phases* have been established in this Cycle, and have:

(a) removed some systemic barriers which had previously prevented this group of service-users from accessing necessary services, and

(b) developed new services within the acute hospital and community settings, specifically for this population.

An illustration of these advances to the service-user's experience in terms of access to and development of services is presented in *Process map B.* here.

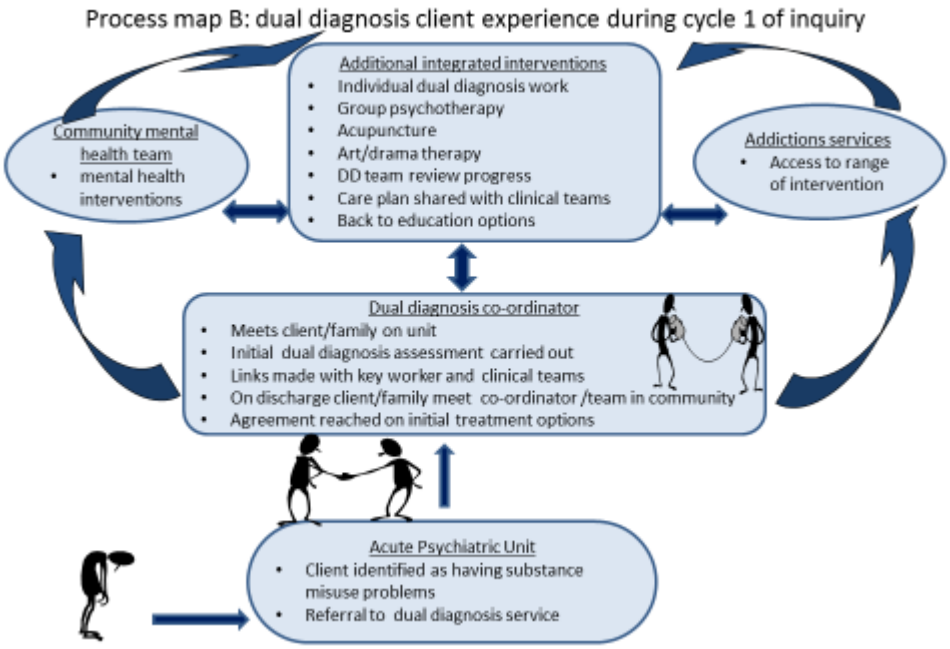

Figure 7. Process map B.

Cycle One participants

These service developments in Cycle One have been facilitated by participating service-users and participants from a range of disciplines within two mental health service areas including mental health nurses, one SCAN nurse, art therapists, occupational therapists, psychologists, psychiatrists, psychotherapists, social workers an addiction counsellor.

Participation over the approximate 18 month period of Cycle One includes:

- Total number of referrals into the dual diagnosis service in Cycle One 720
- 63% represented existing or historical contact with Mental Health services 454
- 37% were new referrals 266

Monthly average participation in data source groups:

- Core research group 32
- MDT group 60
- Psychotherapy group 44

Of note, cross-over occurred every month between the three stakeholder groups and cross-over numbers were inconsistent. For example, some service-users participating in the psychotherapy group have simultaneously participated in the core research group for a number of months at a time, while some organisational employees from the MDT group also participated in both the core research group and as facilitators in the psychotherapy group. Numbers fluctuated likewise within individual data source groups, when staff for example changed jobs, sectors or roles, and/or when service-user disengagement was higher at one time more than another. Furthermore, both the psychotherapy group and the MDT group met weekly, whereas the core research group generally met every six weeks.

Theoretical insight: Though discussed as a rationale above, in this observation phase I recognise the synergy of pragmatism and PAR, as I reflect on the circumstances which influenced the possibility for this inquiry to initially take place. Considering that situation, and thereafter what has occurred in Cycle One, methodologically and philosophically, PAR provides an approach to acquiring knowledge, where participants dictate the course of this evolutionary process through the expression of their collective experiences. However, while one set of circumstances led to the initiation of this inquiry, Cycle One encounters a different set of circumstances, and one which continuously brings new situations and perspectives which were previously unknowable. This is where pragmatism has become visible in this context, enabling us to question what the nature of our experience currently is, what are the most meaningful questions to ask as the inquiry unfolds in unexpected directions, which methods are the most appropriate to apply in answering those questions now, while perhaps necessarily in contrast to what had been previously planned for.

Participants from the three data source groups highlighted, were invited to participate in ongoing data collection and analysis processes throughout the Cycle. What transpired however, was that the core research group members and intermittently participants from the MDT group participated in the collective data analysis processes. The section below illustrates the findings emergent from the analysis, which are supported by selected verbatim data extracts. The use of illustrative quotations emphasises stakeholders' participation, both in data collection and service development processes.

Data analysis

An example of the data analysis process for this Cycle is available in the appendices (Appendix G.). This includes a sequence map of 1. Codes (words, phrases, sentences), 2. Colour coding of categories, 3. Categorisation of emerging themes, 4. Themes, and 5. Sub-themes.

The analysis for this Cycle uses unique identifiers for participants' illustrative quotations. P refers to participant with the number assigned (e.g. ***p.1.5.***) to each participant from the data source groups:

Core research group, data source 1 ***(p.1.1. – p.1.10.)***

MDT group, data source 2 ***(p.1.11. – p.1.20)***

Psychotherapy group, data source 3 ***(p.1.21 - p.1.30)***

Cycle One findings created **two main themes** and **six sub-themes** in total. All themes were reviewed and refined until agreement was reached that the data matched meaningfully and that there were clear distinctions between each theme.

Theme one '**Service Availability**' is presented here, with categories identified across the data sources. Each category is supported with selected verbatim data. From this main theme, **4 sub-themes** emerged. These are presented below, with related categories and supporting verbatim data.

Theme one: Service availability

Findings suggest services need to be made available and developed:

All three groups agreed that a liaison individual was required for family and carers and for staff to be trained in dual diagnosis. A coordinator or key worker was viewed as essential to facilitate service development. However, the psychotherapy group did not express any concerns concerning the referral process as part of the service development.

Categories:

- liaison for family and carers (all three groups matched)

  p.1.4. '*someone needs to interact on behalf of the family and carers, especially at the referral stage – at the moment because of this deficit, families are not sufficiently informed of what appropriate services are available and how they can be a part of that care if the whole family want that – it certainly would be more transparent and would make life easier for all concerned*'

- clearer referral process (two groups matched)

  p.1.7. '*right now this only accommodates two sectors making it quite fragmented in fact – ideally this must be developed across all regional sectors facilitating the options of referring in to practitioners and patients*'

- staff training (two groups matched)

p.1.14. '*our nurses must be trained and upskilled in terms of addiction and I guess likewise – addiction personnel ought to be educated and upskilled concerning medication and other nursing matters in working with this extremely complex group*'

- coordinator/key worker (all three groups matched)

p.1.8. '*In order to bridge this clearly identified care gap, which we've mentioned time and time again, ever before this piece of focused research – which is by the way very positive for us all – a specific individual needs to be positioned to coordinate this at it stands fragmented care – you've got to lobby for this – all well having this gap spoken about on paper or on lovely polished documents, but someone or two people must actually do the foot-work – to make it happen*'

Sub-themes (4 in total)

Sub-theme 1: Availability of appropriate supports: (two groups matched)

Data from both the core research group and the psychotherapy group found that stakeholders proposed and requested that access to services in the context of dual diagnosis should become more available (for example, on weekends and in the evenings), and depending on resources, that more services would become available.

Categories:

- services should be more available

p.1.14. '*the development of roles I believe will enable services that are existing to become more accessible and the development of others to become more available – especially if resources are applied for and received*'

p.1.2. '*there should be more of the services available than what they are…..and someone to talk to that understands both sides of mental health and addiction……and every day not just Monday to Friday, not just during the week like*'

- weekends

p.1.12. '*it would be great if we had classes 'n things at the weekend, as they can be murder, and someone we could call like – weekends can be the hardest as you know*'

- evenings

p.1.17. '*for those of us working I think we must have the same kind of services or at least some of them, available to us in the evenings, even us doing courses too, it's not fair as it is because it's hard to get time off or to be able to travel to get here in time if we're working*'

Sub-theme 2: Communication processes: (all 3 groups matched)

The MDT group discussed communication processes in the context of planning care, while the psychotherapy group discussed communication processes in terms of enhancing their own care. Findings from both of these groups suggested that if communication processes were more effective between participating disciplines and services, care received would become more personalised and focused. Data from the core research group supported these perspectives and believed effective communication processes were central to all aspects of service development, particularly across all relevant sectors, disciplines and in the coordination and planning of care.

Categories:

- confidentiality

  p.1.2.'*confidentiality is fierce important, especially in our groups, it's read out and all that, but I'm not so sure it's always respected like, d'ya know what I mean*'

- family involvement

  p.1.11. '*I don't mind my partner being involved and stuff, like she was when I was in hospital and always like…..but lots of others wouldn't like, or sometimes I wouldn't like her knowing things, but it should be my call, shouldn't it*'

  p.1.9. '*Carers and family members of course can be central to care planning if and when it's appropriate – this has been contentious forever, and we should always aim to optimise this, in the interest of well-being and effective care for all concerned*'

- communication between services or people involved

  p.1.4. '*this may take time and coordination of all disciplines involved, as there exists no clear and open communication pathways between the particular services on report writing for example as it stands – joined up talking would be great, but the inherent system must adapt to your ideals of service provision – however – this is a critical point to address I would imagine*'

  p.1.6. '*this methodology allows a space for us all to share thoughts and ideas that many of us have had for a long time, but there was no 'method' to allow this to happen. As long as this goes on, it gives us time to all be included in the new service as it grows and develops, staff and clients are benefiting from this*'

- care planning

  p.1.10. '*care planning is currently applicable to the particular service- where dual diagnosis is concerned – and specifically if other services are engaging in that care – then the objective is to be collaborative in our approach – we are not familiar with sharing the planning of care*

across services – I'm referring here to specialist services of course like addiction which operate independently of the mental health services – perhaps this needs to change – as you are implying'

p.1.7. '*it's the first time I had an opportunity to get involved in something like this, especially with staff and nurses and to be able to say what ya want is great like, tis very fair to have that*'

- written communication

p.1.22. '*whenever I go to my clinic appointment, I'm wasting my time really as I seem to be repeating myself every month, either I meet someone different every time I go there, or what I said the last time wasn't heard, there's not even good communication between people on the same mental health team, never mind good communication between different teams, it's all over the place if you ask me*'

Sub-theme 3: Education: (all three groups matched)

The psychotherapy group discussed their desire for education in the context of the side effects of medication, stating that this was an important deficit in service provision concerning their care. This data source also proposed education as an urgent necessity relating to a healthier lifestyle, drug and alcohol relapse prevention, and education in general as a route back to employment. The MDT and core research group data sources discussed education in the context of upskilling their knowledge on addiction trends, updated research on dual diagnosis conceptually and clinically, and how non-compliance of medication impacts on an individual's life.

However, all three data sources found that family/carers requested education on dual diagnosis and its implications on an individual's life, in areas including: returning to education, employment, relationships and socialisation.

Categories:

- medication

p.1. 27. '*I'd love to know about the side effects and all that, 'cause sometimes I don't know is what I'm feeling real or is it because of the meds….I know ye've started doing bits on this but it should be in a more routine way as a normal thing kinda, as it is I just get the script and tell the psychiatrist a month later how it's been, if it's fine it's fine, if it's not they might change it, but how am I supposed to know if it's fine or not when I don't know about the side effects, ya a bit of education on that would help*'

- diagnosis

  p.1.24. '*I believe we would all benefit from an informed discussion on diagnostic criterion, and perhaps we should include service-users in this in some way – I'm unsure which is better – together or not – but symptomology and diagnosis would be a good discussion don't you think*'

  p.1.18. '*why don't ye give us a class on what we're diagnosed with, when I try to read the medication leaflets I'm just not at the races at all like, if it could be explained to us it might make sense, what does it all mean anyway – and is this here to stay like – you know –questions like that kinda stuff*'

- addiction and mental health

  p.1.3. '*maybe we could do an educational morning sometime on how mental health influences addiction and vice versa, as we are working with this from the acute unit to here in the community, with little direction and no updated education – it's difficult to pass any of this on to our clients when we are ill-equipped ourselves*'

  p.1.6. '*tis great that both my addiction and mental health are being treated together as for me they're all the one, though I know how services were before this, we should have some education leaflets or something on this though so as we know what to look out for, and to understand what we're going through ya know*'

- diet/exercise

  p.1.13. '*when I'm good I do the samba classes, though I should be doing some bit of exercise all the time as I'm better when I am, when I'm not so good I wish we could do something here to understand what that's all about as it might help get me going as when I've no motivation, I'm just depressed d'ya know what I mean*'

Sub-theme 4: Information: (All data sources matched)

Categories:

- family and individual

  p.1.1. '*We had printed previously a leaflet information sheet on services available in the area*
  and a map of the care pathway from entry to exit points, doesn't this cover what we're doing, or do we need to update it and circulate to all service-users in appropriate locations'

- medication information (data provided above)
- addiction treatment (data provided above)
- available services i.e. therapies = psychotherapy group only

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Theme two: Interventions of care

Theme two 'Interventions of Care' is presented here, with categories identified across the data sources. Each category is supported with selected verbatim data. From this main theme, **2 sub-themes** emerged. These are presented below, with related categories and supporting verbatim data.

Various interventions (including art therapy, mindfulness, tai chi, relaxation, acupuncture and psychotherapy) were discussed by all data sources as enhancing the care of individuals experiencing dual diagnosis. For example, the MDT and core research groups identified the benefits of these interventions from direct feedback from service-users. Service-users participating in the core research group identified these benefits from personal experience. The psychotherapy group identified benefits received from attending that group and other interventions participants had experienced directly.

Sub-themes

Sub-theme 1: Beneficial interventions identified

Categories:

- art therapy
- mindfulness
- group psychotherapy

p.1.19. '*I thought I was the only one who heard those voices; I know the voices aren't half as bad when I'm not using and drinking, but I can talk about it in the group here and that's great for me, especially as I'm now living alone since my Mother died*' ….).

p.1.17. '*I relapsed last year and ended up in hospital and was advised by my psychiatrist to attend this group. I had been attending AA in the past and still do, but I like this group pure and simple because I FEEL comfortable here and it deals with my mental and emotional state along with my addiction. I find it comfortable talking in this group because it is not too big, it's informative and for me I feel at ease talking in here because I feel understood. I never felt that before. In AA I don't feel the same way, I go to AA to listen which is good for me, but don't share as my shyness and anxiety comes to the fore and after I have shared I would be very uncomfortable and hide how I feel. This group is an important part of my recovery and in the maintaining of my abstinence from alcohol and talking about my fears and anxiety that are still there but less, I use it in conjunction with AA and individual psychotherapy*' ….).

- individual psychotherapy
- tai chi
- acupuncture

p.1.26. '*I had fierce anxiety and drinking a slab of lager every day at home when I was referred for acupuncture, I had to be driven to sessions initially because of my anxiety and inability to take the bus. I couldn't go into enclosed areas like the shopping centre. Now, I don't want to drink anymore, my anxiety levels are good enough for me to live my life and I am back working in a rehabilitation work project scheme, happy days….*'

p.1.15. '*After one week's acupuncture I was sleeping more and more. I now sleep without drugs for a full eight hours, my depression is much less and not there, most of the time*'

- individual nurse support
- group relaxation
- anxiety management

Sub-theme 2: Group psychotherapy

Categories:

- comfort

p.1.7. '*could we get tea and coffee trolley like is there in the hospital*'

p.1.9. '*we need more fag breaks, then t'would be easier to be able to be here for the full time, should be able to come in and out, if that's alright*'

- see someone outside the group
- positive feedback
- confidentiality

p.1.11. '*this confidentiality lark isn't working at all, it's important like don't get me wrong, but I'm hearing back stuff all the time… I don't want to be hearing at all like*'

- comfort
- recovery
- boundaries
- feel heard
- everyone the same
- respect
- challenged
- no judgement

Theoretical insight: In my role as facilitator of the core research group (in Cycle One), which was the forum for data analysis, it was often necessary to steer the conversation back to the objectives of the analysis process, particularly as participants became more comfortable with one another, and conversation tended to stray. In the first few months of

the data analysis, I brought much unnecessary stress on myself, trying to be the glue that kept the group analysis process together. For example, in times of disagreement within the group or where I felt some participants were not happy with aspects of the analysis process or with what findings were emerging, in order to counter my own fears of the process disintegrating, with participants potentially disengaging, I fell into the trap of trying to be the peace-maker or trying to ensure that everyone left the meeting on speaking terms at least.

Theoretical discussion emerging

With Cycle One ends in view, the aim and objectives of the inquiry (p.5) are being adhered to, as PAR provides the methodological mechanisms towards achieving the cited goals of service development.

Concerning the internationally recommended '*integrated model*' for dual diagnosis, the literature (including: Drake et al. 2001; SAMHSA, 2009; Hughes et al. 2010; Kelly and Daly, 2013) suggests that addiction and mental health services ought to be integrated in order to comprehensively respond to this cohort's needs, with recommendations highlighting the need for and accessibility to high quality services.

Findings from this Cycle suggest that at a practical level, when appropriate personnel are in place (dual diagnosis coordinator, therapists providing various therapies), appropriate services can be developed and the referred individual can access any service, discipline or agency in their locality that they need. This process has been initiated in Cycle One, with these findings contributing to the evolution of a practical theory (Figure 8 below). In this, participants' perceptions of what a dual diagnosis service ought to include, have informed the ongoing inquiry/service development process. Furthermore, the integrated approach to the development of this dual diagnosis service has become visible from the application of methods of inquiry (instrumentalities), and the formation of the two percepts, '*organisational members buy-in*' and '*the appeal of collaboration*' shaping the perceptual framework for this Cycle of inquiry.

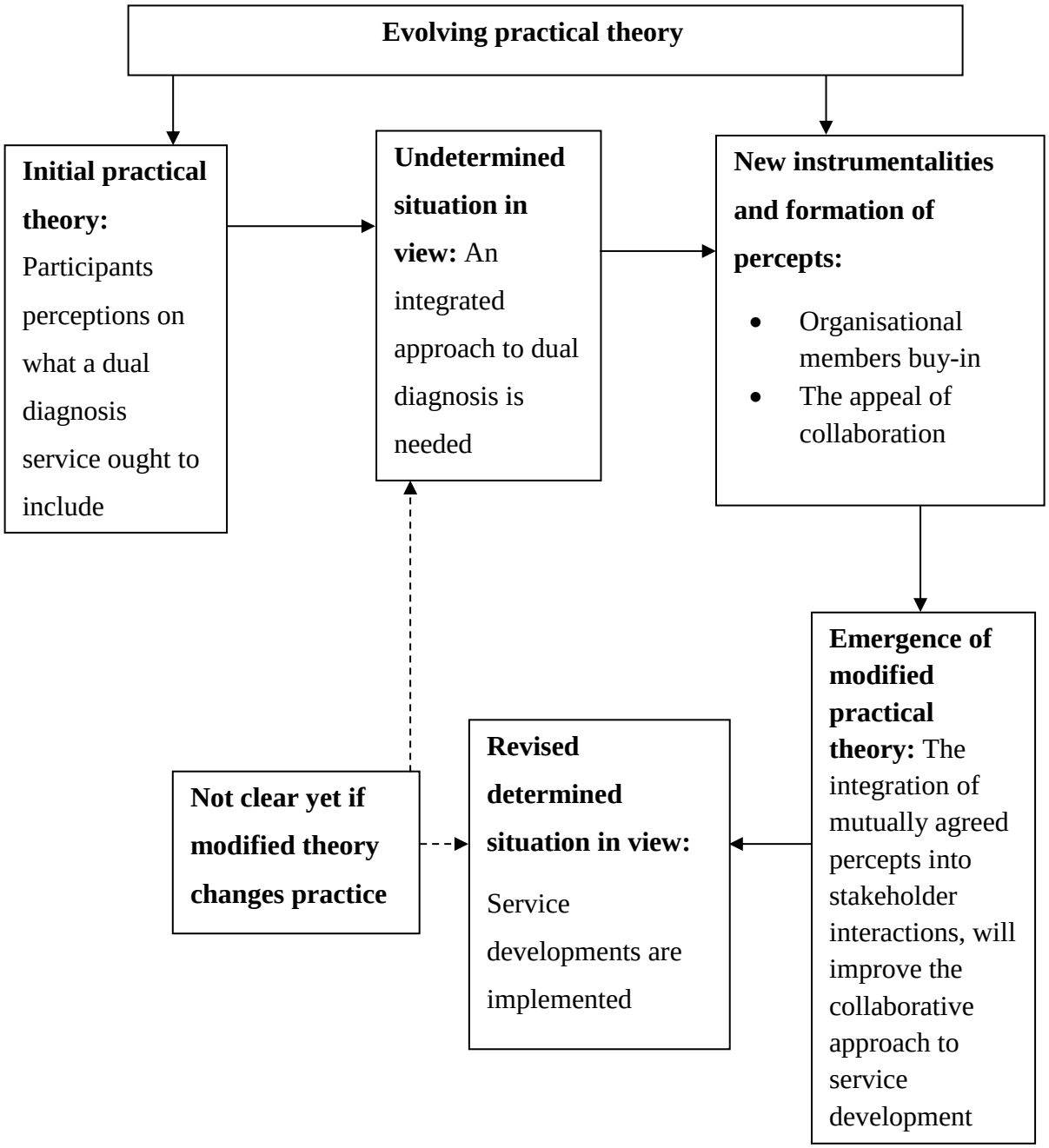

Figure 8. Illustration of practical theory evolving in Cycle One

Ends in view

Stakeholders agreed that these principle actions emerging in Cycle One were the appropriate ones to take preference at this time. These service developments included the implementation of: 1. The coordinating role, 2. The psychotherapy group, 3. The mindfulness group, and 4. The initial development of the referral pathway. The Cycle's *ends in view* were that these actions/service developments had been implemented/started, and that these would continue to be embedded further in the next Cycle.

Although stakeholder engagement was generally positive in this Cycle, as Cycle Two was approaching, concerns were raised about maintaining engagement. For example, service-users were entering the service, their needs being responded to and met over a period of time, and then disengaging, while others engaged over longer periods and actively participated in aspects of the service development. In this, we had some concerns about ongoing engagement from this core stakeholder group, though the apparent reasons for disengagement were agreed by participants to be perfectly normal, and perhaps signified that service-users were benefiting from levels of service provision that was previously unavailable. Ultimately, Cycle One *ends in view* included challenges concerning engagement that will be addressed in Cycle Two.

The processes of service/organisational development progressed as well as they could have given all the influential factors discussed and within the resources available. However, with plans to formalise/embed further these service developments in Cycle Two, participants agreed that at this transitional phase, *ends in view* include the necessity to apply for additional resources to ensure service sustainability.

Albeit informally, it was becoming clear from the Cycle's findings that many stakeholders were benefiting from the initial transformation of services. In this, the Cycle's *ends in view* include initial images of what a contemporary integrated dual diagnosis service may look like.

Findings arising in Cycle One suggest that stakeholders are now robustly engaged in this cyclical process of change, with sufficient energy and momentum inherent in the current participant group to continue in Cycle Two, to embed these organisational service developments which have been initiated in this Cycle.

CHAPTER SIX: RESEARCH CYCLE TWO – EMBEDDING DEVELOPED SERVICES INTO PRACTICE

This chapter is the second Cycle of transformation and which subsequently leads into Cycle Three of the inquiry. The write-up format of this Cycle follows that of Cycle One, where the clearly demarcated phases of *reflection, planning, action* and *observation*, illustrate how service developments materialised within this cyclical framework, as represented in Figure 9 below. As in the previous Cycle, theoretical insights/reflexive observations permeate the text. The overall plans for this Cycle were to:

(a) Embed and formalise the service developments initiated in Cycle One

(b) Develop the referral pathway protocol and the coordinating role

(c) Add individual interviews to data collection methods, and

(d) Apply for additional resources.

To achieve these plans, participants agreed to maintain regular engagement in the core research group process, as this had become an effective focal point from which the majority of decision making processes had taken place in Cycle One. A review of these plans are in the data analysis section of the *observation phase* below (p.194).

Focused discussions in the core research group in Cycle One concerning the development of the referral pathway protocol transitioned smoothly into Cycle Two. Findings in this Cycle dictated the urgent need for the referral protocol, the completion of which took place in this Cycle, where current and potential referral sources received a copy of the document. Findings from Cycle One informed decision making for Cycle Two, whereby the development of the overall dual diagnosis operational policy, which includes the referral protocol and all other aspects of service provision, occurred in this Cycle. However, the process of implementing the service operational policy occurred in Cycle Three.

Findings from Cycle One concerning data collection suggested that the method of recorded one-to-one interviews would take place with stakeholders in this Cycle. I agreed to conduct

the interviews and manually transcribe the data, with the core research group participating in both the analysis of the interviews and in the ongoing analysis process conducted throughout the Cycle, from April 2014 to August 2015 approximately. As participant observation proved a productive data collection method in Cycle One, I proposed to continue with this in this Cycle, with other members from the core research group similarly agreeing to adopt this method.

The disengagement of certain participants became an unexpected problem in this Cycle. However, the employed methodology guided the resolution to the disengagement and reengagement process in the Cycle, with a stakeholder-workshop taking place in order to reengage participants in the inquiry process. Although a positive intervention in terms of its short-term outcomes, the process of reengagement inspired questions concerning stakeholder's resistance to change, both from an individual context within the inquiry itself, and within the broader organisational context.

Cycle Two also included the collaborative process of constructing an application to peripheral stakeholders (the organisation's management team) for additional resources. Findings from Cycle One had highlighted the necessity for this application, if the service developments implemented over the course of the inquiry were to be sustainable.

Figure 9 here illustrates the cyclical phases of the overall Cycle, signifying the processes that occurred within each phase of this Cycle, each of which I explore in the relevant sections below.

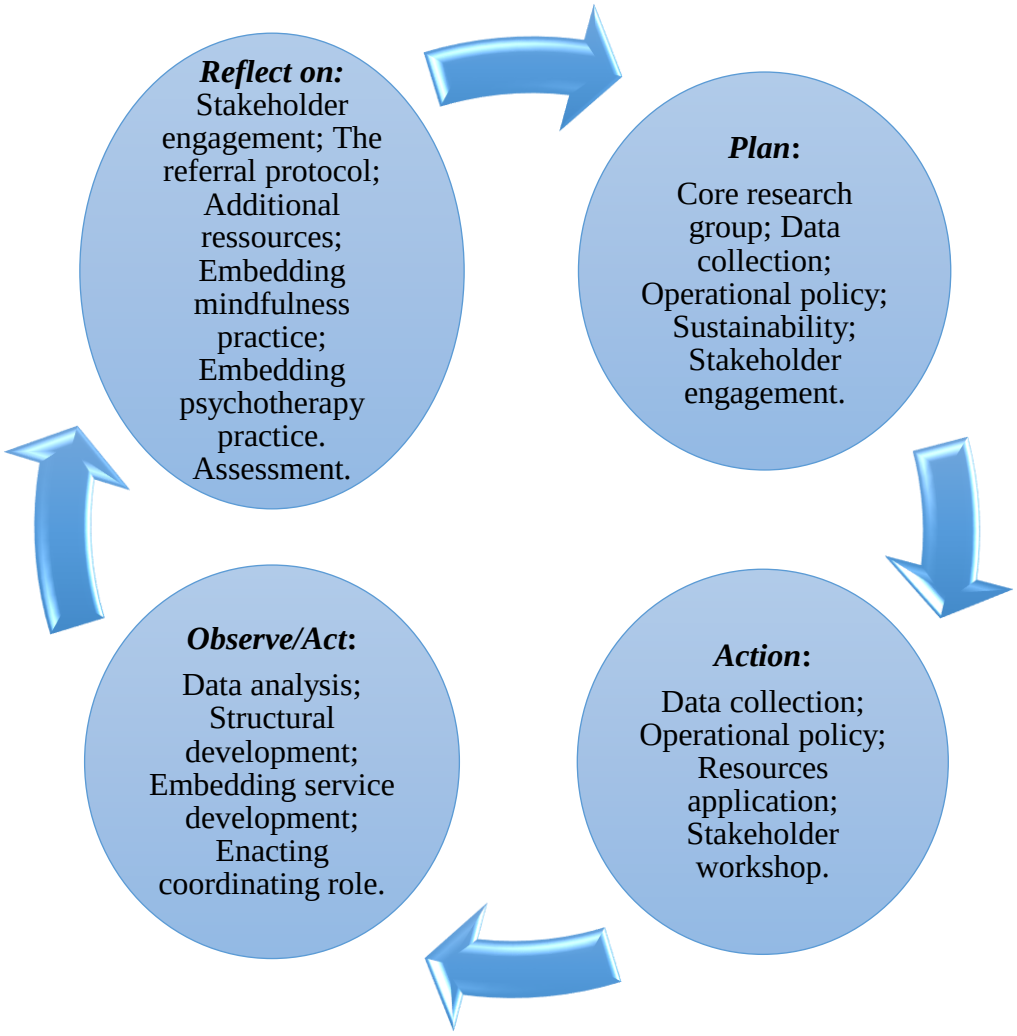

Figure 9. Processes occurring in Cycle Two

Reflection phase

As in Cycle One, this reflection phase focuses on the processes that have taken place up to now, forming a methodological bridge, which subsequently informs the following cyclical processes of inquiry. Inherently, this Cycle demonstrates how as a process, reflection was employed and what we have learned from how reflection occurred both in individual and group contexts, with this being central to the development of actionable knowledge (Argyris, 2003).

Theoretical insight: In terms of the core research group, one of the agreed plans was to begin each meeting with a collaborative-reflective phase. Though meetings had varied time constraints, as facilitator I aimed to remain as true to this previously agreed plan as much

as was practically possible. However, within the busyness of the practice setting, participants frequently resisted collaborative reflection at the beginning of meetings and proposed as this only being necessary when some of the more critical elements of service development required reflection. While it was unnecessary to collectively reflect on issues of less importance, especially when many participants frequently just wanted to get on with the pressing issues emerging, because of such time constraints. Embracing my own role(s) in this Cycle, I learned to be less rigid about adhering to such previously agreed upon plans. Inevitably, elements of collective reflection emerged from almost all discussions and meetings, though maybe not in the structured way I had originally thought was ideal. In ways, particularly concerning the importance of inter-personal communication within this group, once I became more open in this Cycle to the diverse possibilities from which reflective practice can occur, collective reflection on actions and on the evolving process, invariably emerged.

Our experience of engaging in reflective practice has developed over time, as we shared our learning from experience through both individual (journaling) and core research group processes (Connolly et al. 2015). As Reason (2003) notes: '*part of our task as action researchers is to re-describe inquiry*' (p.119). These collective processes enabled varied aspects of reflective practice to emerge, incorporating what Reason and Torbett (1999) refer to as first-, second- and third-person research practice. This became the vehicle from which the understanding of our research process became discussable and explicit as the Cycle unfolded (Reason, 2003; Dick, 2015). Throughout the Cycle and in between the highlighted groups (MDT, core research group, psychotherapy group), there was consistent reflection in action, a process which in itself continued to inform subsequent actions, and where mutual insights were continuously being co-constructed. As part of this process for example, group participants were reflecting on changing practices as they occurred, which has informed the overall reflection on this Cycle and its evaluation by the core research group. However, the evaluation of this Cycle occurred more as a process over many group discussions (including groups with varied objectives), rather than any evaluation consensus arising from within the core research group.

Findings from Cycle One shaped the service developments that occurred in this Cycle, reflections on which I illustrate here. However early in the Cycle, and in order to achieve the Cycle's plans (as described above), the engagement of stakeholders became one of the Cycle's primary objectives and is reflected upon here, prior to reflecting on subsequent service developments.

Reflecting on stakeholder reengagement

Many benefits emerged from the stakeholder disengagement, re-engagement process, including the implementation of a stakeholder-workshop, which re-engaged those participants who had disengaged, while simultaneously recruiting participants that had recently joined the organisation in varying departments/disciplines. How stakeholders disengaged in the first place may have had something to do with how individual and collective reflection processes were effective or not in terms of communication within the 'communicative space' of the core research group. Or simply how certain staff had planned to leave the service (for retirement and/or maternity leave for example), and that these facts did not enter the dialogic space of the core research group until they had left, also may say something about the employee's relationship with the organisation, and indeed the employee's relationship with this inquiry/service development, within the organisation.

However, this appears to be how staff routinely come and go within this organisation/service. For example, employees notify the HR/personnel department of their impending departure, be it for retirement, promotion, changing sectors, other career options or otherwise, and other various types of planned leave. This organisational system locally however, seems to not react to this planned staffing deficit until it has occurred, leaving the service provision in a temporary and often prolonged state of flux where practices become quite reactionary. This was most evident in Cycle Two when the consultant psychiatrist who was leading decision maker for many years on one of the mental health teams, retired. From her retirement date, five months passed before a locum psychiatrist filled that role, despite the organisation being aware of her upcoming retirement. Apart from the probable clinical nuances, which ensued following this departure, other members of that team subsequently appeared to be particularly stressed from that lack of direction, with this unrest also negatively impacting participant's engagement with our inquiry process. From discussion with my methodological supervisor about the reality of this disengagement (the details of which are discussed further below, pertinent to the *planning, action and observation* phases of that process), a possible resolution to the dilemma emerged. In order to address stakeholder disengagement, a stakeholder workshop was planned for and implemented.

Is the organisation ready for change?

Reflecting on the relationship that stakeholders have with this process of organisational change, stakeholders have both resisted and disengaged from this dual diagnosis service development process in this Cycle of inquiry. This brings into focus, both the individual's and the organisation's readiness for change. In this, while individual readiness for change has been subject to considerable empirical study and theoretical development (Fischbein and Ajzen, 1975; Prochaska and DiClementi, 1983; Bandura, 1986; Bandura, 1997; Rogers, 2003; Heimlich and Ardoin, 2008; Sharma and Romas, 2012), theoretical models concerning organisational readiness for change does not appear to feature as much in the literature. Reviewing this dichotomy, both Holt et al. (2006) and Weiner et al. (2008) respectively found the instruments employed to measure organisational readiness for change to be unreliable and invalid, and with varying interpretations of the meaning of organisational readiness for change being evident in the literature. For us in this inquiry context, to propose that *organisational readiness for change* is a multi-faceted construct (Weiner, 2009), where elements of readiness can exist in any individual or organisational level, may help inform our understanding of this emerging percept which came into view early in this Cycle. In this, the formation of this percept became a question: *Is the organisation ready for change?*

In this regard, if definitions of organisational readiness include commitment to change and change efficacy of its members to implement change (Weiner et al. 2008), this suggests that individuals may need to be both psychologically and behaviourally prepared to engage in action, in order to bring about that change (Weiner et al. 2009). In terms of commitment to participating in change, Herscovitch and Meyer (2002) suggest that organisational members who engage in such because they want to, demonstrate the highest commitment to implementing change.

Reflecting on theoretical frameworks informing change

In this inquiry context, whether the organisation and/or individuals within it were ready or not for the changes that PAR has brought about in Cycle's One and Two, an overview of the following theoretical frameworks inform this reflection by highlighting the presence of certain conditions within an organisation that may boost its readiness for change. For example, drawing from elements of motivational theory, (Vroom, 1964; Fishbein and Ajzen, 1975), the notion that when organisational members value the particular imminent change, the greater

the chances of their participation in implementing aspects of that change. For example, when organisational members think or believe that the change is needed, beneficial or worthwhile either to themselves or to others, the more likely they will feel motivated to participate in actions to bring about that change (Cole et al. 2006). While findings in this Cycle suggest that participants have valued this organisational change (data analysis below), it would be disingenuous to suggest that any or all of such subjective reasons in themselves, would be sufficient to bring about organisational readiness for change. In keeping with PAR's methodological and philosophical approach, and notwithstanding individual-motivational reasons for participation and indeed disengagement, organisational members have collectively valued the systemic changes sufficiently enough to participate in the implementation of the plans which had been made for Cycle Two.

From a social cognitive theory perspective, Gist and Mitchell (1992) propose that an organisation's change efficacy includes its members' cognitive evaluation of the particular tasks required, the resources available and other contextual factors. The authors suggest in other words that organisational members while cognitively constructing capabilities of performing tasks in relation to implementing change will likely ask themselves or others: Do we know what it takes to implement this change effectively? Do we have the resources to do so? Can we implement the change within this context? It is thus reasonable to suggest that change efficacy is high when organisational members collectively share a favourable agreement to these factors leading towards implementing change. Considering this social cognitive theoretical perspective, and the fact that actions in this and all Cycles of inquiry are socially constructed and occur in real-time, findings from this Cycle have included both these questions and answers (data analysis below).

Reflecting on this, it appears that despite the evidence of some participants' resisting and disengaging from the inquiry process during this Cycle, there were sufficient stakeholders actively participating in all elements of the Cycle to demonstrate (data analysis below) that:

- The organisation was ready for this planned change, and
- That stakeholders were actively participating in change.

Considering the overall process of stakeholder disengagement and reengagement in this Cycle, the two distinct percepts: '*Is the organisation ready for change?*' and '*The*

organisation participates in change' were formed. While these percepts emerged independently of one another, their connection is demonstrated throughout the remaining phases of this Cycle, and continues into Cycle Three.

Theoretical insight: What I learned from this stakeholder disengagement process, was that I could have managed and planned for these upcoming changes in a more proactive manner which may have created a space for contingencies to be strategically planned for with the wider stakeholder group. For example, I (like many other participants) knew that these staff were leaving for many weeks/months beforehand and I had not facilitated the planned change in a way that engagement in the inquiry process could have been maintained in a way which could have reduced the impact of stakeholder disengagement at this time. I was aware of team members' fear and uncertainty (of their team leader-psychiatrist retiring) as people were expressing it, but rather than in a sense colluding (by saying nothing) with that hypothetical air of uncertainty and perceived lack of direction.
On reflection, I could have facilitated a planned change approach that at least may have maintained engagement in core research group and other central functions to the inquiry. However, while this learning could have been pre-determined, the disengagement that happened occurred in real-time, with the experience of the entire disengagement and reengagement process informing (i) the planning and implementation of the next Cycle of inquiry, and (ii) the processes of reflection, while also raising my level of awareness of the diverse roles I assume during the inquiry. This process has critically informed '*the organisation's readiness for change'* percept, whereby in the absence of planning for the active and continuing participation of stakeholders, the inquiry process can potentially become redundant. In this regard, this percept contributes to the evolution of a practical-theory-formation taking place.

Reflecting on the referral protocol

Findings in this Cycle (illustrated in *Observation phase* below) demonstrated considerable participant demand for the referral protocol. Developed as an entity in itself, the protocol was ultimately included in the operational policy document, for the attention of all potential referrers. Figure 10 below illustrates the referral protocol, which is included in the service's operational policy document (Appendix J).

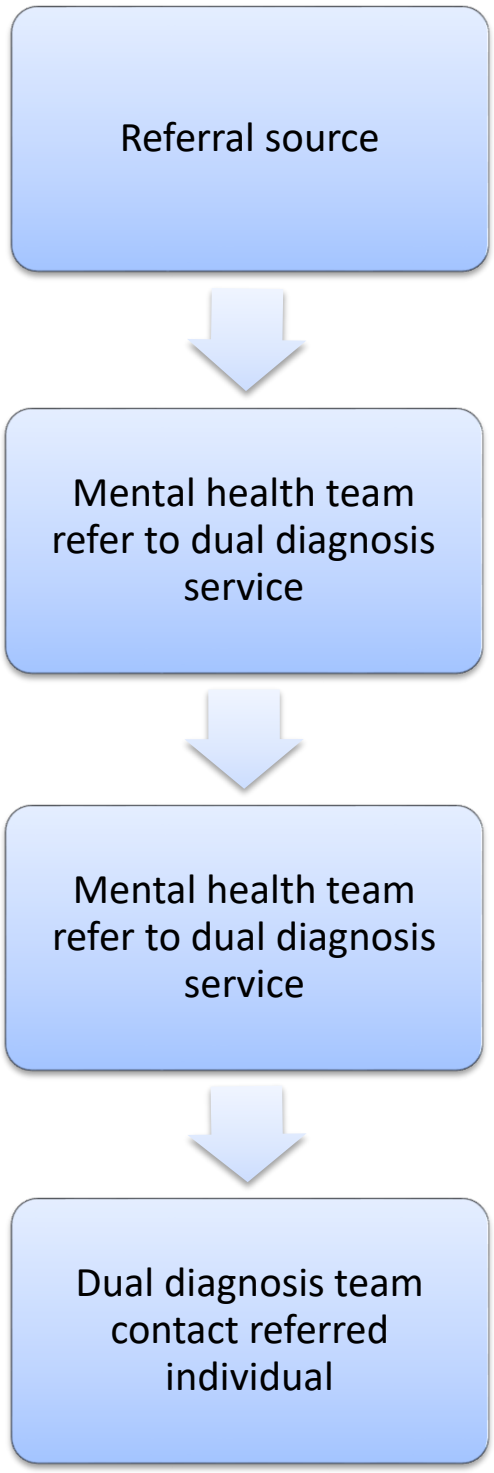

Figure 10. Process map of referral as illustrated in the referral protocol document

While negotiating details of the protocol, participants agreed that potential referrers must have access to this document as soon as possible in Cycle Two. This decision emerged from analysed data, which illustrated that many stakeholders urgently required knowledge of the process of referral into the service. While the protocol was included in the operational policy document, once participants agreed, all existing and potential referral sources within the participating sectors received a copy of the working document. As referrals into the service were increasing, from Cycle One to this Cycle, so too were the sources of the referrals broadening from across Cork city and county. Figure 11 below illustrates the sources of referral in this Cycle.

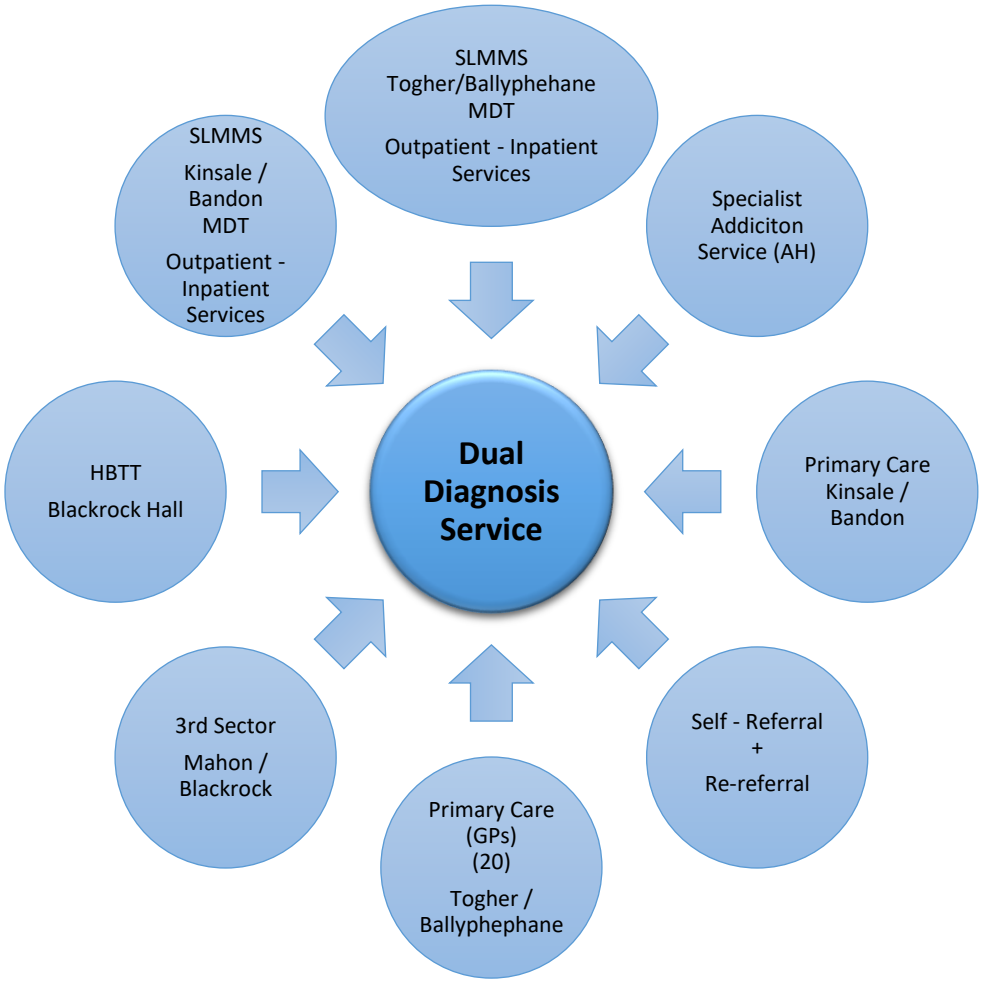

Figure 11. Sources of referral into the service at this phase of the inquiry

The *planning, action and observation* phases of the referral protocol are in those respective sections below.

Additional resources

Findings from Cycle One informed the application for additional resources in Cycle Two. Participants agreed that further resources were required for the sustainability of the service. The evolution of this application process took considerable time, the processes of which are discussed further below within the relevant cyclical processes of inquiry. Reflecting on that developmental process, has highlighted both the benefits of making such an application from evidence gathered on the ground, and its limitations in terms of its efficacy of accessing applicable budgets locally, at least within the relatively confined timeframe of the inquiry. The benefits of co-constructing such an application has highlighted the appropriateness of the methodology, which has facilitated the participatory approach to it. The fact that the application occurred as part of an active research inquiry and ongoing dual diagnosis service development within the overall mental health service, highlighted the need for this new dual diagnosis service, which was demonstrated in the findings from Cycles One and Two. Considering these factors, the timing, approach and implementation of the application seemed appropriate to Cycle Two. However, within such a hierarchical organisation where this inquiry takes place, the process of making such an internal application has its challenges. For example, follow-up emails to the local management office on the status of the application have remained unanswered, indicating over the phase of Cycle Two, that even if the application had been considered, any decisions have not been communicated to the stakeholder group that sent it. In terms of what services have been developed and embedded over Cycles One and Two, and the necessary resources required to sustain these developments, while also acknowledging the ends in view of the inquiry process timeframe, this demonstration of resistance from within the organisation was concerning. Participants agreed to continue the follow-up emails throughout Cycle Three or until the application was responded to.

Implementation of mindfulness practice

Mindfulness classes were an additional service development initially implemented in Cycle One, with this Cycle enabling the embedding of this resource into routine dual diagnosis practice. At the start of the psychotherapy group that started in Cycle One, we introduced ten minutes or so of mindfulness simply with the intention of focusing participant's attention on

being present in the group. Most participants enjoyed this start to the group and requested more of it. Further discussions with this group found that mindfulness classes/sessions were delivered within the mental health services, though access was somewhat compromised by waiting lists, and with participants having to come from particular sectors in order to eligible to participate, which was a further barrier to entry. Considering such systemic complications, we locally explored the possibility of including mindfulness as part of our own service development, whereupon collective agreement the core research group discussed the proposal. One participant (CNS) who had trained as a mindfulness facilitator agreed to deliver eight weekly sessions at a time with service-users from our group. The implementation of this occurred swiftly and has continued throughout Cycle Two with participants entering and leaving the sessions as they wish. Participating numbers have fluctuated though active participation remains. As the practice of mindfulness within the overall dual diagnosis service was embedded in this Cycle, it took up little time in the core research group thereafter. Only for example where data analysis processes found mindfulness to be a meaningful and desirable addition to the overall service, which stimulated some discussion on the process itself, its benefits for some participants and challenges for others, though with mutually agreed decisions to maintain this additional service. Loose plans have been discussed in the core research group about others putting their names forward for facilitator training, while all had gone well over the phase of this Cycle, the over-reliance on one nurse currently filling this role, had been agreed as being unsustainable.

Implementation of psychotherapy practice

As a service development initially implemented in Cycle One, this Cycle facilitated the embedding of the psychotherapy group into practice, whereby findings (in data analysis of *observation phase* below) demonstrated that this development had become a regular feature of the service and desire for participation in the group remained high.

Reflecting on the embedding of psychotherapy as a service development process in Cycle Two, highlighted the findings from this Cycle (data analysis in *observation phase* below) which demonstrate that participants have sufficiently maintained engagement in this process to embed this service development into routine practice. While the findings illustrate that participants benefited from this development, the evidence also demonstrates that a broad

range of participants requested more within the broader realm of psychotherapy within this dual diagnosis service.

Theoretical insight: Some participants (facilitators) who had facilitated this psychotherapy group with me in Cycle One appeared to be uneasy, disinterested or maybe lacked understanding of the nuances concerning dual diagnosis. At times, I felt I was facilitating the group alone, with the co-facilitator just sitting there and avoiding eye contact with me or refraining from participating in the facilitator role or from verbally engaging in the group at all. This I found challenging over an average 90-minute period of the group process, equally difficult to address thereafter, as for many reasons (not least ethical and professional) two facilitators are required for such groups, and at the time, nobody else was interested or available to do so. However, from an application made in Cycle Two to the local mental health service the group process now benefits from facilitators who are appropriately equipped for the role. For the multiple roles I assumed within the inquiry, and specifically in facilitating this group, I found it difficult to ascertain and resolve the challenging dilemma of working with a co-facilitator who appeared to be ill equipped to fulfil the role, although the developing service utilised existing resources. From my perspective, reflecting on this learning from experience highlighted again the implementation of training need for personnel assigned to particular roles in the context of dual diagnosis.
The scope of this inquiry does not allow for exploration of the service-user's perspective in this regard (Faulkner, 2003). Though suffice to mention here, that it may be particularly challenging to ascertain how the group's participants (service-users) experienced the 'behaviour' of the group's facilitators, as findings from Cycle Two concerning the psychotherapy group did not allude to the facilitation of the group in any way (Stickley, 2006).

Reflecting on the additional service development of psychotherapy as a group construct, what has emerged is that some service-users from their experience of this group therapy have expressed a desire to initiate individual psychotherapy. As options available within the local mental health service or local specialist addiction services were frequently discussed by participants, some service-users requested access to private psychotherapy (for example, outside of the organisation), and were willing to pay (albeit low-cost options) for that service.

(Within the local mental health service, solution focused psychotherapy offers 6-8 sessions, with availability to those whom are abstinent from alcohol and all illicit substances as a preliminary/mandatory entry requirement).

Some service-users that started such individual therapy continued to participate in the group therapy on a weekly basis. This appeared to have a positive-motivational influence on others in the group, particularly those new to the group. Although considering the attendance at group

psychotherapy over Cycle Two, the percentage of those who started and remained engaged in individual private therapy was 5% (approx.). There are probably multiple factors that have influenced this, although findings from this Cycle demonstrate in the *observation phase* below that individual psychotherapy may require planning within this organisational setting in the context of dual diagnosis service provision.

Assessment

The literature review chapter discusses the mental health assessment process in general and assessment concerning dual diagnosis in particular (pp.51-53). The dual diagnosis assessment process emerged in Cycle One within the context of one of the initial service developments in that Cycle. In that Cycle, where personnel on the acute unit referred someone to the dual diagnosis service, the dual diagnosis assessment commenced at that juncture on the unit. That initial bio-psycho-social assessment became the starting point of what organically became an ongoing assessment process. Core research group participants in collaboration with others directly involved in the individual's care agreed that such an integrated care process seemed to be consistent with the individual's recovery process, whilst enabling the unique and evolving story of the individual to emerge over time. Participants agreed that this extended approach to assessment reflected elements of the *case-construction approach* adopted by Faber et al. (1996), and the *case-formulation approach* proposed by Vanheule (2017). In this particular context of dual diagnosis service development, it was mutually agreed to observe this collaboratively-integrated and longer-term approach to assessment. While both standardised screening and substance use/mental health assessment tools have been employed in practice and were included for recommended use in the service's operational policy document, participants agreed that the multi-disciplinary long-term approach to assessment was more aligned with responding to individual's changing complex needs. After collective agreement, the assessment process naturally took place over the longer-term in this Cycle. Though apart from the application of the standardised assessment tools and the collaboratively constructed extended assessment process, the diagnoses that informed the initial referral featured very little in this Cycle. In Cycle Three, further discussion includes the assessment process, as it relates to further service developments in that Cycle, and as assessment relates to the overall aim and objectives of the inquiry.

Planning phase

This section describes the planning processes that occurred concerning the principal actions that took place in this Cycle. In this, I will introduce here the planning functions of the core research group and that of the data collection process. Also described here are the planning of the dual diagnosis service operational policy, the application for additional resources and the stakeholder reengagement process.

Core research group planning

In the early planning stages of the Cycle, the core research group was interactively robust and engaged on discussions of all service development related processes. However, as described above in the *reflection* phase, from June to October 2015 (approx.), some stakeholders disengaged, which adversely affected participation in the core research group. In terms of *planning* during these months, decisions that needed to be made were made by fewer participants than that of Cycle One, and although collaborative input was compromised from a numbers perspective, the limited amount of participants in the core research group worked sufficiently well enough to maintain some level of momentum at the time. Apart from the period of dis-engagement early in this Cycle, and notwithstanding those participants that had disengaged, the general familiarity and spirit that developed within this group over the previous Cycle, continued into Cycle Two. This seemed to facilitate more focused participation within the group, especially once the re-engagement process had taken place. This in turn positively influenced all decision-making processes over the remainder of the Cycle, where participants in the core research group appeared to take a greater sense of ownership in the overall inquiry process. This renewed energy was evident during various planning stages over the Cycle, though as it was more than what anyone actually said, it was difficult to decipher, though from observation was definitely present.

Theoretical insight: The fluctuating engagement of participants within the overall inquiry context and particularly within the core research group contributed to *the appeal of collaboration* percept continuing to be equally relevant in this Cycle. Within this however, the notion of participation exists and seems to be more complex, particularly when considering the relation that power has, with the application of participation in practice (Chinn, 2004, 2016). For example, the organisation's structure is by its nature hierarchical, evident by our communication to management in this Cycle, illustrating the power differential where inquiry participants applied to the organisation's management for additional resources.

Power differentials (Chinn, 2013c) are equally present though, within the dynamics of the core research group. Where participants holding various levels of power as insiders in the organisation may choose to participate or not in the research group in accordance to the levels of power they assume in the organisation. As an insider in the organisation, and as lead researcher in the inquiry, I also invariably participate in the inquiry in accordance to the level of power I assume in the organisation and within the inquiry context, as each participant probably does. As I and other insider organisational members engage in participatory approaches, particularly with participants who may be in more vulnerable, less powerful positions in the inquiry, as co-researchers our individual-internal hierarchical structure may require consideration within the context of participation (Webler and Tuler, 2001; Gustavsen, 2002).

Planning data collection

The three data source groups participating in Cycle One continued to function in this Cycle, with emergent data informing the overall inquiry process. However, findings from Cycle One demonstrated that participants proposed the data collection method of individual interviews would take place in this Cycle, which was in adherence to the aims and objectives of the inquiry. I agreed to conduct the interviews, with the core research group agreeing to continue with the collective analysis process, which reconfirmed participant's engagement as co-researchers again in this Cycle. The core research group, whilst appearing to be developing into a more critically reflective forum in this Cycle, were largely reaching collaborative agreement on emergent findings and subsequent processes of planning, which in itself strengthened the quality of the reflexive process of our inquiry. For data analysis purposes, the core research group planned to meet every 4-6 weeks as this worked well in Cycle One, though many of us met on numerous occasions from one week to the next in more informal settings, including staff rooms and the community centre canteen. Within many of these informal settings and where appropriate in many of the organisation's waiting rooms, we planned to update the notice boards of any changes and service developments as they were occurring. This objective was to inform other colleagues and service-users (who may not have been participating in any of the groups referred to above, or in any aspects of the service itself) of days/times of meetings and groups, contact details and an open invitation to inquire about participation in the inquiry.

Excerpts from the data collection and analysis selected for this Cycle's write-up are included in the *observation phase* below.

Service operational policy planning

Cycle Two plans included the formalisation of service developments which had evolved informally in Cycle One. By formalisation, what participants agreed was that as services were developing and becoming more accessible to service-users in practice, the critical aspects of this dual diagnosis service provision, whilst documented, ultimately required approval by the organisation's mental health management team locally. This mutually agreed objective was to: (i) symbolically signify the implementation of the developed services over the course of the inquiry, (ii) act as a practical guide to all aspects of the service that any potential referrer may require, and (iii) would potentially contribute to the service's sustainability beyond the timeframe of the inquiry. Planning discussions on this stirred much debate over the course of the Cycle, and included plans for the development of policies for both the referral protocol and for the role of the dual diagnosis coordinator. Findings from Cycle One guided and informed these discussions, although participants found it challenging to find agreement on how this formalisation process was to be realised in the form of one document. For example, attempts at planning one document for the referral protocol and another for policies and procedures ensued in disagreement, as participants (mainly organisation employees) previously experienced in policy development in other areas of the organisation, preferred the option of aiming towards developing one document, to include all aspects of the service. This seemed to make sense for many reasons, not least for practicalities such as any agency or service (GP's) locally referring into the new service, would have all relevant data on one document. Another reason was that participants agreed that aspects of the referral process and the service-user's subsequent engagement with services overlapped with the role(s) of the coordinator. Considering these nuances, participants agreed that one document ought to outline the delivery of services clearly. Ultimately, all participants agreed on this, and set about planning *the dual diagnosis service operational policy*. The *action phase* below includes discussion on the evolutionary development process of the full policy document.

Resource planning

As referred to above, the service developments established in Cycle One have taken place while utilising the organisation's existing resources. Findings from Cycle One however illustrated that the provision of these newly established service developments over the longer term would be unsustainable in the absence additional resources. The general list of potential

planning items constructed by the core research group early in Cycle One had identified *resource planning* as an action more appropriate to Cycle Three. Because of the findings that highlighted the demand of and benefits for the service, participants of core research group agreed that resource planning was to begin as soon as possible in this Cycle.

An application to the HSE's mental health division for additional resources was thus planned for, with initial plans based on findings and the collective stakeholder agreement that core elements of the dual diagnosis service which had been planned for, was becoming realised in practice, and sooner than previously expected. This realisation in Cycle Two coincided timewise with the publication of the *HSE's Mental Health Division Operational Plan, 2016*, which cited action plans to include the delivery of clinical programs for dual diagnosis nationwide:

> ('*Design and implementation of the agreed two further clinical programmes prioritising responses to children and adults with ADHD and those with Comorbid Mental Illness and Substance Misuse (Dual Diagnosis)*'. p.9).

With this potential opportunity for us locally to be considered for such funding appropriation, and on the basis that the inquiry process was now demonstrating findings/evidence of an effective service (albeit yet informally), planning this application was mutually agreed as appropriate and timely. Another agreed upon objective was that as an established MDT and research group responding effectively to dual diagnosis in these two sectors of Cork city and county, the additional resources applied for, would potentially save the organisation (HSE) the potential costs of what implementing the complete components of a full clinical program would be. Of note, the implementation and embedding of this new service over the course of Cycle's One and Two have occurred whilst utilising the organisation's available resources. (29 participating health care professionals signed this application; service-users participated in these planning discussions and while actively supporting the application, for ethical and confidential purposes refrained from signing the document). As illustrated in the application (Appendix D.), the additional 4.5 posts applied for includes the objective of expanding this coordinated response to dual diagnosis to the remaining six sectors of Cork city.

The *action phase* below illustrates the application process as it happened.

Stakeholder disengagement, reengagement planning process

As detailed in the Methodology chapter above (pp.90-95), one of the principle reasons for choosing PAR, as '*an orientation to inquiry*' (Reason and Bradbury, 2008a, p.1) in this environmental context, was its applicability to engaging a broad range of stakeholders in the participatory process of inquiry. Findings from Cycle One had demonstrated that maintaining stakeholder engagement was a concern for all data source groups, where engagement was believed to be the foundational-collective force which was driving service development, and a force upon which the sustainability of the inquiry process relied. However, five participants who participated in both the MDT and the core research group left one of the mental health teams that were participating in the inquiry. Specifically, one consultant psychiatrist retired, one CNM II and three mental health nurses changed sectors and/or roles, while one mental health social worker took maternity leave. Although these career changes routinely occur within this public health service organisation, and had been planned for individually with each employee's respective HR department/line management; however, when this exodus took place (almost simultaneously), the dynamics within the mental health team and that of the inquiry process were adversely affected.

As discussed, planning processes changed, though because of this departure, some other remaining participants also appeared to lose interest at this time, with the momentum gathered over Cycle One seeming to dissipate, albeit for a short few months. Although it was only five individuals that had left out of a total twenty-nine (at that time) from this stakeholder group, they had been key participants who had engaged enthusiastically in data collection and analysis processes, as well as each of them being key links to the core stakeholder group (service-users) on a day-to-day basis. As I integrated with and observed some of the remaining participants during this period of staff transition, many expressed disinterest in their work in general from this change within the organisational system. This period of flux also coincided with summer holidays, when many staff took annual leave, which further complicated the disengagement situation.

Theoretical insight: In the absence of any policies or protocols concerning such disengagement, I felt as though the research process was being compromised, and in a sense uncontrollable, as if it was like sand flowing through my fingers, which I could not hold onto. Though a radical change I believed was required, in mid-August I contacted and met with my research supervisor and formulated a plan of action. As this disengagement dilemma was happening, it reminded me of my own academic bias

(referred to above) as I navigated this particular planning process. Experiencing this current position as a percept in the context of *stakeholder disengagement/re-engagement*, it re-emphasised the bias of there being potentially an academic benefit for me with the successful completion of this research, with thoughts including, '*if stakeholders do not re-engage, will the research be a failure'*. Though catching my attention, and ultimately gaining some necessary objectivity (psychologically) from such thoughts, this percept brought with it, the reality that while I have a facilitating/coordinating role to play within the inquiry, and it is ultimately a participatory process that can only be realised through the active engagement and participation of stakeholders. Within this, the concept of participation re-emerges for potentially further discussion in the context of this complex group of stakeholders.

While findings from Cycle One identified stakeholder engagement as an important concern for all groups, this disengagement problem in Cycle Two abruptly brought the criticality of stakeholder engagement to the fore at this time. For example, in terms of planning meetings over Cycle One, the predominant focus of discussion was on matters pertaining to service developments. This was with participants actively participating, though coming and going from the core research group from one meeting to the next, with little or no attention given to the potentiality of members of the core research group leaving the organisation/inquiry process permanently, and that planning ought to include the management of such disengagement.

With support from my research supervisor, I planned to contact all internal and external stakeholders, inviting them together to Cork University Hospital (CUH) for a one-day workshop to (a) reflect on developments already achieved in Cycle One, (b) review/plan agreed-upon remaining service development objectives, (c) identify any challenges emerging, and (d) introduce new incoming staff to each other.

Figure 12 below signifies the overall disengagement – reengagement process as a cyclical process in itself, with details of the workshop process discussed as it happened in the *action* phase below.

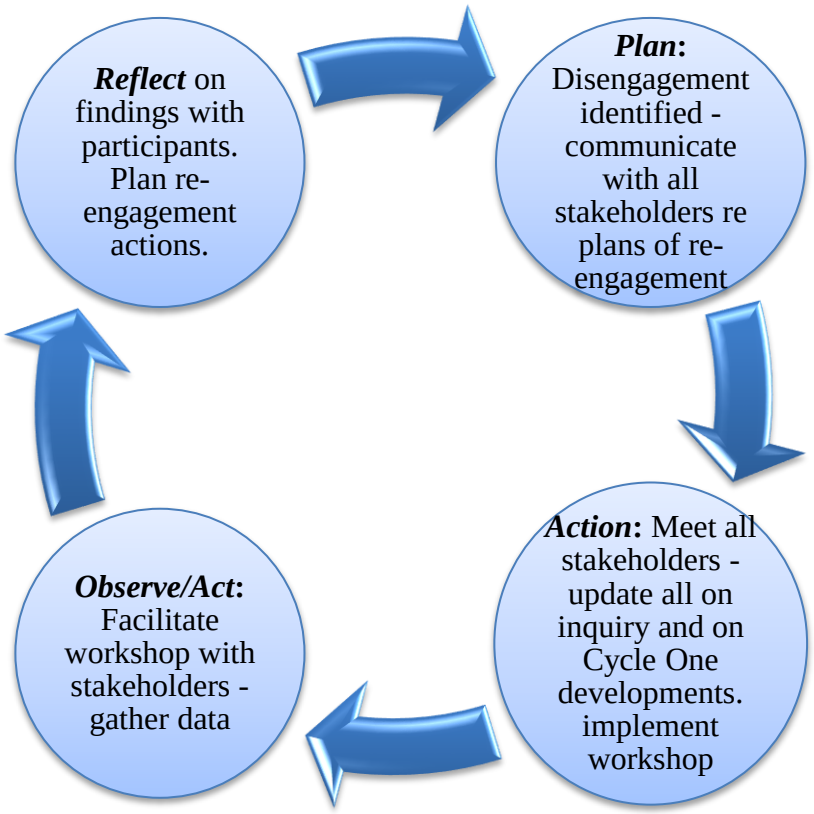

Figure 12. Cyclical process of stakeholder re-engagement workshop

Action phase

This phase of the Cycle included two broad functions: (i) actions that took place by conducting the varied methods of data collection, and (ii) actions informed by the findings from Cycle One, which have propelled the embedding of the service transformations over this time. This section also describes the implementation of the primary actions planned for in this Cycle, and the actions that unexpectedly emerged, demanding a swift, practical response. Following this section, the *observation phase* below subsequently illustrates supporting verbatim data excerpts from stakeholders participating in varying capacities in these service transformations.

Plans for this Cycle were to embed into practice those developments established in Cycle One. Findings illustrate benefits for participants from the service transformations that occurred over the phase of Cycle Two, which include a broader group of participants. For example, service-users began to report their subjective experience of these service developments to other organisational members including psychiatrists, junior doctors, occupational therapists and

community mental health nurses. These practitioners meet with service-users at outpatient clinics and within other services in the community and being located in neighbouring services/sectors, may not be actively participating in the inquiry process itself. These healthcare professionals began to express an interest in our developing service, with particular requests concerning referral into the service. Though such requests were reassuring in terms of there being a broader demand for the development of and access to new services for this group of service-users, the primary objectives for this Cycle were to embed further into practice the developments that had evolved informally in the previous Cycle. These plans included strengthening the methodological inquiry process, with the additional data collection method of individually interviewing participants.

As highlighted above, the core research group was instrumental in this transformation process, whereby all the collectively analysed data continued to inform and update the embedding of ongoing service developments over the Cycle. Though many critical aspects of the transformation process (including the development and implementation of the dual diagnosis operational policy) spanned Cycle Two and continuing into Cycle Three, mainly because of disagreement amongst participants concerning the contents of the document, which consequently delayed the implementation of the policy locally.

What helped to bridge this period of negotiation, were the previously cited plans for data collection for this Cycle. Where data from the three group sources analysed above in Cycle One continued to be gathered similarly in this Cycle, this ensured continuity in terms of the core research group's data analysis process, whilst simultaneously the findings from such continued to inform the overall service development process. Implementing the method of individual interviews in this Cycle included two additional data sources, namely, service-users and healthcare professionals.

Stakeholders agreed that potential findings from the emergent data would robustly inform and update the formalisation process.

Data collection

Plans to implement focus groups as a data collection method in this Cycle did not go ahead as core stakeholders (service-users) resisted the proposed method of application. Findings from Cycle One demonstrated two general reasons for this. One was that the focus groups were being recorded (thoughts of being recorded made service-users feel uncomfortable in a group

setting); the other was participants said they could concentrate better and felt more relaxed in a one-to-one interviewing situation. This in turn favoured the action of conducting individual interviews that was agreeable to all stakeholders from the two proposed sources. Respecting the thoughts and feelings of core stakeholders was an important ethical concern to uphold for this group, where methods of data collection and analysis were acceptable to those who are of central focus to the inquiry (Flick, 2009; Dempsey et al. 2016). Furthermore, the construction of questions for interviewing service-users focused on the research question and not on eliciting any personal or sensitive issues. In this, when working with topics which may be potentially sensitive (Corbin and Morse, 2003; Enosh and Buchbinder, 2005), reasonable and appropriate safety measures ought to be implemented, with the objective of reducing risks associated with the invasion of privacy and breaching confidentiality (Brydon-Miller, 2012; Russo, 2012; Mealer and Jones, 2014).

Participants in the core research group developed interview questions for the two data sources. All service-user interviews took place in a comfortable pre-arranged setting, with interviewees transported to and from their home by taxi, if they wished. The interviews with healthcare professionals' took place in various clinical settings across the sectors within the inquiry context. The *observation phase* below includes excerpts from the data analysis.

Operational policy development

Cycle One findings informed the plans to develop an individual document illustrating all aspects of the service. The core research group eventually agreed in this Cycle that developing the referral protocol as an independent document was a priority, though ultimately forming part of the service's operational policy document (Appendix J.). Findings from Cycle One concerning the coordinator role, also informed these discussions, and became part of this operational policy development process. Participants agreed that this role was central to the referral process, though findings from Cycle Two highlighted its limitations in terms of capacity. For example, as described above, when staff on the acute unit contacted the coordinator regarding a new referral, the coordinator went to the unit as soon as possible to start the initial assessment process and engagement with the service. Starting from this hospital intervention, the coordinator role in Cycle Two evolved into that of navigating the person referred through all the services, buildings and departments in the community that the individual required, over the initial weeks and months of engagement with this service. In

terms of dedicated time and focus, the core research group agreed, that this was what was required in order to reduce the service-user's potential disengagement from the services, which (as described above) had previously been a service delivery problem for this population. However, for the interim coordinating role that I was filling as part of the inquiry process, it was becoming clear that in order to fulfil this role comprehensively, a dedicated role was required to manage the referral systemically, and an additional role(s) was required to actualise it in practice, requiring considerable time for this each day. The challenges of the role could not have been pre-determined, nor could the necessary supports for that role have been pre-identified, had the role not been temporarily filled. In this, participants agreed that for the sustainability of the service in the context of the referral pathway and where the coordinating role necessarily dovetailed with the referral process, link-workers were required to support that coordinator role in practice. In the context of implementing an integrated dual diagnosis response model in the UK, Edwards (2011) highlights the introduction of link-workers to help facilitate such integration, while evidence from similar models of care in Australia (Canaway and Merkes, 2010; Merkes et al. 2010) had helped to bridge this previously identified gap in service provision there. Findings from Cycle Two supported with evidence from the literature informed the application for additional resources (see below) concerning these roles.

Participants in the core research group agreed that although the organisation's area management team had yet to approve and subsequently formalise the service operation policy document, a working draft copy of the policy was to be positioned in appropriate workplace locations upon completion.

Resource application

Findings from Cycle One informed initial stakeholder discussions concerning additional resource planning. This interactive process focused attention on constructing an application to the office of the organisation's mental health division (HSE). This resulted from core research group meetings which explored the recommendations cited in the *Mental Health Division Operational Plan, 2016*, (HSE, Mental Health Services, 2016, p.9) discussed above, and which were linked to the necessity of additional resources becoming a reality for our inquiry in practice, in this Cycle. Participants agreed that as those of us who led the inquiry process and employed in both primary care and mental health sectors, we should firstly

communicate with this hierarchical tier locally, with the objective of supporting the application to the national office. (Of note, both primary care and mental health divisions, come under the organisation's structural umbrella of the Department of Social Inclusion.) On this basis, I requested and met with the local Primary Care development officer, the coordinator of drug and alcohol services for Cork and Kerry, and the head of the Social Inclusion department in the South West, all of whom became peripheral and supporting stakeholders in this resource application.

The application (Appendix D) included a detailed overview of the service, with the following recommendations made for its sustainability.

> *'The dual diagnosis service development illustrated above has been feasible because of this particular coordinated approach to service provision, which has occurred utilising existing resources (see: Connolly et al. 2015, p.37). For its enactment to date, an interim coordinator helped facilitate this development in the Togher/Ballyphehane and Kinsale/Bandon areas of Cork city. In order to ensure sustainability of this working model and to further develop the service across Cork South (see areas listed below); the following posts are required:*
>
> - *One full-time dual diagnosis coordinator*
> - *Two dual diagnosis link workers*
> - *Administrative support (0.50 W.T.E.)*
>
> *These posts would be the only additional costs required to deliver the service comprehensively. Fully implementing and resourcing this particular care pathway will:*
>
> *(a) Adhere to recommendations made in the Vision for Change policy document highlighted above*
> *(b) Fulfil the objectives outlined in the HSE's Cork and Kerry, CHO Operational Plan, 2016, (pp. 68/69), and the HSE National Service Plan for 2016*
> *(c) bring this Irish working model in line with international best practice (Bell, 2014; Edwards, 2011) for dual diagnosis service delivery*
>
> *In addition to maintaining the service in the Togher/Ballyphehane and Bandon/Kinsale areas, with the proposed posts in place the aim is to develop this service in the following geographical areas:*
>
> *Carragline/PassageWest; Douglas/Frankfield/Grange; Blackrock/Mahon; Ballincollig/Bishopstown; Greenmount/the Lough.'*

While the core research group constructed the application, further communication with the above-mentioned peripheral stakeholders, culminated in a collective decision to submit the application to the Mental Health Section of the Local Health Office (HSE). The core research

group nominated a participant to follow up this application with an email on a quarterly basis, requesting updates on the application process.

Stakeholder reengagement workshop

The first overall inquiry objective was *to engage stakeholders in PAR's methodological framework to facilitate a clear pathway to services* (p.8). From this, Cycle One discussed broadly the engagement of stakeholders as important to the inquiry process, though disengagement had not presented as a problem at that time. When participants began to disengage in this Cycle, the existence of *the appeal of collaboration* percept remained evident. As previous phases described the context of participants disengaging, plans for the reengagement process came about swiftly, as the shifting stakeholder environment dictated this participatory option. From discussions and agreement with the coordinator on one of the participating mental health teams, I met individually with each incoming employee as part of their induction process, as the vacant posts were re-filled. This objective was to update everyone on the primary objective of the inquiry/service development, the developments to date, and to invite all to the planned workshop as a method of reengaging and introducing new and existing stakeholders. I also met with the incoming locum psychiatrist, the newly arrived staff on the MDT and on the acute unit, the South Lee Primary Care development officer, participating hospital and community team leaders, providing a background to and updates of the service. I highlighted the necessity for the workshop in order to regain focus on the aim and objectives of the inquiry, through this collaborative process. Fortunately, these initial individual meetings culminated in a general enthusiasm for the service development and a willingness from all incoming staff to participate in the inquiry process.

As I met with as many stakeholders as possible while planning the workshop, this however provoked some initial resistance about the location of the workshop. Some participants agreed that the newly opened acute mental health unit on Cork University Hospital (CUH) was the ideal location, as so many stakeholders were familiar with or worked in the hospital environment. However, without explanation, personnel on the unit denied the request to conduct the workshop there, although while further exploring the nuances concerning the booking of the specific training room that was required, we discovered that UCC's medical

school held responsibility for that training room, which fortunately led to its reservation for a full morning for our planned workshop.

Theoretical insight: Even though 'resistance' had not been a radical barrier to service development so far, elements of such had emerged in Cycle One, where stakeholders' (healthcare staff) strongly resisted partaking in individual data collection methods, including journaling/note taking. In this Cycle also, stakeholders (acute hospital unit management), in more powerful organisational positions, denied permission to accommodate the re-engagement workshop. (After holding the workshop, the same personnel rejected proposals for dual diagnosis interventions (including acupuncture sessions) on the unit, despite recommendations by the locum psychiatrist).

While many organisational stakeholders welcomed and have actively participated in key aspects (both data collection sources) of the inquiry process, the collective experience of such resistance illuminates and brings into question the percept of *the organisation's readiness for change*, at various levels. Within this, stakeholders assuming diverse roles within the organisation exhibit both subtle and overt permeations of power and control (Foucoult, 1977, 1979; Hildyard et al. 2001; Self and Schraeder, 2009; Wamba, 2016) in their interactions with one another.

Concerning the inquiry's aim and objectives, the methodology has facilitated the democratic resolution of power imbalances (indifferences in the core research group for example emerging in Cycles one and two) between participating stakeholders on the ground. What concerns me though is the following: considering that within the process of achieving these collaboratively determined objectives, the organisation facilitates and supports the inquiry based on both the needs of the service-user and the identified needs of the organisation. Paradoxically, the development and implementation of these objectives meets resistance from those holding various levels of power within the organisation itself.

Within the inquiry's timeframe however, can such power relations up along the hierarchy (which we have challenges in openly communicating with), influence proposals made in this Cycle for such sustainability. Further, if such resistance remains, how can we negotiate our proposals of service sustainability? (Self, 2007; Raelin, 2012)

Beyond the inquiry's timeframe, how will the competing power relations affect transformations that have taken place? In terms of embedding these work practices on the ground in this and the next Cycle, as we communicate with powerful organisational forces, how can we as participating stakeholders utilise our collective empowerment in this formalisation process?

The recording of the workshop as a method of data collection in Cycle Two did not occur, as it would have been unethical to do so without participants' permission, whereas the primary objective of the workshop was to re-engage stakeholders, rather than a method of data collection. On this basis, we agreed that taking notes of the experiences throughout the workshop and thereafter, would be sufficient and appropriate data to inform the overall analysis process. My research supervisor agreed to co-facilitate the workshop, where we collectively introduced the subject of dual diagnosis as a local and national clinical concern,

which had led to the impetus for the inquiry. We reflected on Cycle One and benefits to all stakeholders, which ensued robust participation from many service-users who attended. Thirty-nine stakeholders attended, representing service-users (both of those actively engaged and not in the inquiry process), and the organisations employees (representing disciplines of psychiatry, nursing, psychology, general practice, occupational therapy and addiction).

Service-users' participated in a very active way, verbally illustrating real life examples of why the service was important to them and how they and their families were benefiting over the period of Cycle One from the coordinated integration of local services, which they stated had been previously inaccessible to them.

Findings from the workshop included:

- new nursing staff from acute hospital unit requested participation in the core research group
- participants proposed specific dual diagnosis training for mental health staff in conjunction with the development of dual diagnosis related initiatives on the acute unit
- a representative from HSE management highlighted the necessity of a new post, a dual diagnosis coordinator, with the objective of sustaining what had developed and ultimately proposing to develop the service across all HSE sectoral areas in the city
- recent delays/blocks to developing referral pathways into the service were explored by me and referrers present on the day and were resolved effectively, and
- proposal made for acupuncture to be routinely included as a new service in the acute unit in the hospital

Theoretical insight: This *action phase* in Cycle Two highlighted the challenges of implementing planned actions, while simultaneously realising the applicability of the methodology to an ever-changing complex environment such as this. For example, facilitating the implementation of the stakeholder workshop as a participatory method of reengaging participants emphasised the suitability of this methodological approach. This was a dilemma which had initially seemed daunting (in terms of disengagement) turned out to be a catalyst for change in a way that could not have been foreseen, or which may not have been facilitated by a competing research approach.
Also, as a philosophical stimulus, the action phase of this Cycle has demonstrated that pragmatism has exceeded its narrow associations with practicality, whereby the experiences

and beliefs of participants in this social context, have been directly linked to the actions taken, which underlie this collective search for knowledge.
Considering such methodological and philosophical influences in the inquiry process and the findings created to date, undoubtedly service transformation is taking place within the organisational system, at least on the ground. Concerning sustainability, the application for additional resources has occurred, though the delivery of such may be reliant on forces (political/budgetary) outside the realms of this local PAR process.

A summary of actions occurred in this Cycle include:

- Data collected from a broad range of participants, utilising diverse methods
- Development of the *Dual Diagnosis Operational Policy* document
- Application made to organisation's management for additional resources
- Stakeholder reengagement workshop conducted

Observation phase

As in Cycle One, processes of *observation* permeated the actions that took place in this Cycle including the concretising into practice of those service developments that stakeholders believed to be meaningful and beneficial to them. Though some actions were implemented as planned for in this Cycle (resource application for example), the evolution of some other service developments and especially those related to the pivotal roles required for service sustainability purposes, spanned this full Cycle, and as referred to above, also became part of Cycle Three. While the core research group reformed after the disengagement experience, findings demonstrate that other stakeholders (organisational employees in particular) some of whom had initially participated in planning and implementation phases of Cycle One, thereafter in this Cycle actively demonstrated resistance. Some disengaged from the inquiry process and from the local mental health service without explicit notification to co-participants in the inquiry, while others left the organisation for good also without informing co-participants. This has brought into question the notion of the relationship an employee has with the organisation and how this can facilitate or potentially disable such planned organisational change/development.

As Cycle One findings had informed plans for this Cycle, the data gathered in Cycle Two in turn informs developments in this and the next Cycle. Braun and Clarke's (2006) method continued to direct the analysis process in this Cycle, a sample of which is illustrated in the

appendices (Appendix H). The analysis includes data analysed from the recorded interviews, excerpts from which are illustrated below as they relate to both the aim and objectives of the inquiry and to the plans and actions that took place over the Cycle. The selected data excerpts relate to the emergent themes, with the illustrated data including discussion and reflective commentary as the findings inform plans for Cycle Three.

Theoretical insight: The way this Cycle unfolded, deepened the experience of both the method and the process of *observation*, where a lot of flux occurred requiring the making of imminent decisions, which were not pre-planned. Actions tentatively planned for Cycle Three required action in this Cycle, demanding an oblique observational perspective from what was occurring in real-time, while simultaneously participating in the action taking place. Though happening within a similar timeframe, and to be fully engaged in all aspects of the activity, the process of taking mental and/or physical notes brought with it a necessary objectivity from observations made, in order to observe effectively. This was both individually and collectively (core research group and other informal ad-hoc discussions) engaging, where I took notes, thought about, researched and discussed with other participants the varied aspects of such observations. Within this democratic process, some important observations have collectively informed decision making, while those of less importance may have not. However, because of the co-occurrence between the process of observing and the live activities which happen within the inquiry process, it seems that observations which have the capacity to be individually or collectively processed quickly, have a greater chance of being acted upon, and thus influencing decision making. Alternatively, observations made some time ago (days, weeks or months, depending on the context), seem to have had little influence on affecting decision making, once time has lapsed from when the observation was made. However, where the process of observation is relevant to the data analysis process (and the emergent findings which influence decision-making), this insight appears to be paradoxical. The literature (Hart and Bond, 1998) supports this action research co-occurrence, where the cyclical processes of action and observation/evaluation merge effectively in practice (pp.54-55).

Cycle Two participants

Service developments embedded in this Cycle were enabled by participant service-users and participants employed by the organisation including mental health nurses, one SCAN nurse, art therapists, occupational therapists, psychologists, psychiatrists, psychotherapists, social workers and an addiction counsellor. Participant sample over the sixteen month period of Cycle Two (approx.), include the following:

- Total number of referrals into the dual diagnosis service in Cycle Two 480
- 40% were referrals/re-referrals from mental health service sectors 192
- 60% were referrals from GP's 266

Monthly average participation in data source groups:

- Core research group 18
- MDT group 48
- Psychotherapy group 36

All referrals from general practice (60%) and from within the organisation's mental health services (40%) in this Cycle were new referrals. Of the 40% (192) from mental health services, 28% (53) were from the Togher/Ballyphehane sector. Of that 28% (53), 75% (39) were hospital based referrals, with 25% (14) presenting at OPD. The precise overall numbers of new or re-referrals were not collected, as a CNM II from one participating mental health team (Togher/Ballyphehane) agreed to collate this data, while no one offered to collate such from the other team (Kinsale/Bandon). As in Cycle One, some referred participants engaged for one appointment and did not attend again in this phase. Others engaged upon referral and intermittently engaged in services, while others presented at various times after the referral was made, or did not act on the referral at all.

With the inquiry/service development operating on the organisation's existing resources, it was challenging to coordinate/request participants to collate/manage data that collectively represented both participating sectors. While service-users were able to be referred into the service from both sectors, it was not possible to determine what overall percentages of mental health service referrals were referred to the dual diagnosis service. However, 6% of overall new referrals to the Togher/Ballyphehane mental health team over this time period (01/04/2014 to 31/08/2015) were referred to the dual diagnosis service (100% = 879. 40% of 879 = 53).

As in Cycle One, cross-over occurred each month between groups and the cross-over was inconsistent. For example, some service-users participating in the psychotherapy group have simultaneously participated in the core research group, while some organisationally employed participants from the MDT group also participated in both the core research group and in the psychotherapy group. Additionally, numbers fluctuated within individual data source groups, when staff changed jobs, sectors and/or roles, and when service-user engagement levels varied. Also, both the psychotherapy group and the MDT group met weekly, whereas the core research group generally met every six weeks.

Data analysis

The two data sources were: **1. *Healthcare professionals***, and **2. *Service-users***. The core research group designed the interview questions with the aim and objectives of the inquiry in mind, considering the particular context of the two data sources interviewed. For example, the primary focus for the *healthcare professionals*', data source (1), was in the context of providing access to services, while for the *service-user's*, data source (2), their subjective needs in terms of service provision was the area of primary focus.

While the respective data sources (1 and 2), represented participants engaging in diverse capacities with the organisation (service providers and service-users), the data analysis illustrates the findings and the integrated analysis of their collective engagement with the service development.

The themes and sub-themes emerged from this analysis are illustrated here with supporting data gleaned from the relevant data sources, followed by discussion on each theme as it related to the overall inquiry. A further example of coding, (colour) categorisation of codes and emergent theme is illustrated in Appendix K.

Cycle One findings informing Cycle Two

The referral process

Findings in Cycle One revealed that the referral process was unclear and confusing for those professionals who did not have local access to the new service or to those not working in or near it. While those working on local mental health teams and related services found access relatively straightforward. Cycle Two findings stated that healthcare professionals without easy access to dual diagnosis related services (working in neighbouring or other city HSE sectors) were unsure what the process of referral was. They were also unsure if they themselves could refer into the new service, and if they could, they were unsure what the method or process of referral was. Those healthcare professionals with local access to the service again reiterated how easy it was to refer in, though believed the constant turnover of staff negatively impacted on local knowledge concerning the process of referral.

Service-users in Cycle One were primarily referred to either the addiction or mental health services by their GP. Again, in Cycle Two, service-users were referred to either mental health

or addiction services by their GP, however the main difference now was that the mental health and addiction services were now referring directly into the dual diagnosis service.

Findings concerning the referral pathway in Cycle One were similar in Cycle Two. Participants' reiteration of the absence of a clear referral process inspired an immediate response to complete the referral protocol in this Cycle. The completion and local dissemination of this document made the referral process more transparent and user-friendly to participants and to those requiring referral into the service. Cycle Two findings also demonstrated that service-users were unaware that self-referral was an option.

The analysis here illustrates the abbreviations used for participants on transcripts of the recorded interviews. P refers to participant with the number assigned (e.g. ***p.5.***) to each participant within the following data source groups:

Healthcare professionals, data source 1 (***p.10 – p.17***)

Current service-users, data source group 2 (***p.1. – p.9***)

No formal coding for silences, pauses and intonation were employed for transcribing purposes, though pauses are signified, with the longer pauses written in text and shorter pauses with concurrent full stops, with each full stop signifying one second and subsequent full stops additional seconds. Where the recording could not be deciphered, the text indicates the unclear text. The phonetic sound and colloquialism of an utterance is illustrated where there are misspellings in the text.

Theme 1: Identified need for a structured referral pathway

Findings in the context of service sustainability demonstrated the need for a referral protocol (see Operational Policy: Appendix J). While the protocol became an entity in itself, once developed, it was included in the overall service operational policy document for dissemination across the region. Both data sources expressed an interest in having access to the service via a structured referral pathway, with participants stating that a sustainable service ought to ultimately include all mental health sectors of the city. Participants stated that those with familiarity to the dual diagnosis service found it easy to refer and gain access, by either using the standard referral form or making a telephone call. However, for those with limited access (professionals outside of the sectors where the inquiry was taking place, or within it but still unaware of the new service) there were concerns about an unclear referral process.

Participants stated that others personnel were unaware of the referral process or what they could or could not access in relation to dual diagnosis. Participants believed the frequent change and turnover in staff, negatively affected knowledge of relevant services. Participants not having direct access to the service (including those operating outside the two sectors participating in the inquiry), identified the referral process as confusing and were unsure how to proceed if a client needed these services. The majority believed only the consultant could refer and were unsure how to go about the process of referral.

p.10. *That staff are aware of the kind of personnel or kind of clients that would be suitable to be referred or that they might need some advice on ... maybe a little bit more streamlined might help*

p.10. *I think with changes in staff maybe within teams and it's not consistently clear……. I think that has to do with new personnel who are not aware of the service or who the service is available to. So, I think it's not as visible as it could be.*

p.12. *There's been times where working on the ward as well as the community I was unaware of a bit of contact and there was no clear pathway of what to do when I had a service user needing a dual diagnosis service.*

p.12. *what's the pathway - who is going to own this person and it seems to me to be a gap, but no one, particularly once regressed, particularly in mental health.*

p.13. *I suppose it's just a phone call and the usual referral forms – so there are no issues around that at all. It's very straight forward.*

p.14. *the doctor in charge or the consultant. As far as I know it would be the consultant that would make the referral to the dual diagnosis team, as far as I know anyway. I haven't much experience of it and I've never referred anyone myself to a dual diagnosis team.*

p.15. *From our perspective, it's more the consultants that would refer and it depends on what consultant you're actually working with as if they can refer to the current services. You have clients that are there and you know that they would need something like a dual diagnosis service but you can't refer directly. And it's only certain sectors that can refer so if it was open to every sector and everyone could refer it would actually be really good.*

p.15. *I'm not sure exactly how I would go about it anyway. If there was something there that said this is how you start, this is how you finish and at least you could follow.*

p.15. *Am, again I suppose from a ward perspective you have clients that are there and you know that they would need something like a dual diagnosis service but you can't refer directly. And it's only certain sectors that can refer so if it was open to every sector and everyone could refer it would actually be really good.*

p.16. *we would have good links with the dual diagnosis service so it's is easy to refer by email, by phone or the community mental health team referral form.*

p.17. *I think that it's important to say – it's not an automatic routine kind of referral into the service*

Service-users expressed their experience of referral into the service, via their GP or various hospital and mental health services, while being unaware of the self-referral option. Of note, the self-referral option has been included in the service operational policy. For service-users, the focus was not on the referral protocol or on access to the dual diagnosis service per se, but on the source of their initial referral. The majority stating initial referral to either mental health or specialist addiction services by their GP, and thereafter accessing the dual diagnosis service via personnel working in their respective sector whom had knowledge of the new service.

P.1.*Through my GP. When I was on a detox from the benzos, he referred me to an addiction counsellor, that's how I ended up in the group.*

p.2. *i spoke to my doctor, and he wanted me to go to em AAMHU and I'll be honest with ya I just i just said like no i really don't to go there so he recommended i go and see ah the mental health nurse in T?*

p.3. *when I reached a crisis with my addiction I went to my doctor and I was referred through A&E to see a psychiatrist and from there referred on*

p.4*. well it was through my own GP, ...cos eh ...i was going through ...em.. the addiction, and then ...i was finding myself depressed, and I was wondering was that because of the addiction or what have ya, but they were two separate issues... i was just being...treated for the addiction emm there was nothing or no one was doing about the mental health ...but i bloody knew i wasn't right like*

p.5*. from the girls above in the hospital where we go out the clinic out in T I was referred to a girl in you know in DP then?*

p.6. *hmm my GP Y and ...I'd a breakdown as such like and he sent me straight up to ...CUH ...and eh was it GF is the right word is it? And em a doctor saw me and then I was contacted by JC*

p.7. *Through my doctor. He just gave me a number to ring and we talked on the phone for a while and set up an interview / assessment.*

p.8*. ahh through .... B.M. my psychiatrist in GF*

p.9. *I initially accessed it through my social worker ah COS and she put me in touch with JC. She would have been there since GF*

Sub-theme 1: The coordination of integrated care

The need for designated staff and identifiable roles emerged as lacking in the developing service. All participants in Cycle Two viewed the coordinating role positively; potentially leading to better outcomes, ensuring individuals would move from being service dependent to service-users. Participants viewed the coordinating role as facilitating coordinated-care and simplified the response to dual diagnosis in an integrative way. This integration of care positively influences an individual's overall wellbeing, while reducing the likelihood of someone slipping in-between services. The coordination of integrated care likewise facilitates joint working between services. Participants believed that other therapies, previously inaccessible to service-users, ought to be a routinely accessible in the general of mental health services. In the context of sustainability, service-users expressed the need for dual diagnosis services to be available on a wider scale, for example, in evenings and weekends. Participants highlighted the need for healthcare professionals to integrate between the environment of primary care and mental health in the context of developing dual diagnosis services, while training provision for designated staff emerged as essential in the provision of a streamlined service.

p.11. *in, my view the only way to do that, not in all, but in many cases is to approach them at the same time as opposed to sequentially. I can imagine in other sectors that don't have any kind of co-ordinator, you know am, am co-ordinating individual (am, am) that that would be a problem.*

p.11. *I think if we could have a greater managerial type role co-ordinating both an input of the addiction services and an input of the mental health services for a given individual, perhaps someone who had a key worker role, involved in, even in the practicalities like lining up appointments at an appropriate time, so I would see there being a role for, say, a co-ordinator with more addiction counsellors on the ground…*

p.11. *I can imagine in other sectors that don't have any kind of co-ordinator, you know am, am co-ordinating individual (am, am) that that would be a problem.*

p.11. We know that those with addiction and indeed mental health problems, are, can be poor to engage and I think someone who could be proactive and serve as a co-ordinating role for the two services would be very helpful.

p.13. *I suppose (pause) having more addiction counsellors that are attached either, like, like your own role employed by primary care but attached to the mental health or if the mental service themselves could incorporate (pause - unsure) it might actually work better if it's a joint kind of approach between primary care and mental health because then you've got a foot in each kind of aspect of the service. (pause) But equally I can see a role for addiction counsellors (laughs) on all our teams.*

***p.13**. Am I suppose it would be great to see it across all sectors. It's unique to just two areas so that means that there's not kind of equality and access to this type of service really so it would need to be broadened out.*

***p.13.** Obviously the two are quite entwined but having access to specialist services is hugely beneficial, We've got really kind of good direct access but I would imagine then other teams that don't have that relationship with the primary care addiction service (am) that they would find that more difficult. I don't actually*

***p.14.** So I suppose from that point of view from their loved one would benefit from the service so in turn they get help*

***p.15.** Whereas if you had a co-ordinator, you know one person is taking care of all that*

***p.16.** I think service-users get a better service and family members because it's in existence.*

***p.16.** I suppose it would be great if the service was expanded because (pause) there is definitely a need, particularly, in ……. area for increased support around dual diagnosis issues.*

***p.16.** It would be great to have it integrated on the team so that you have a dual diagnosis staff member on the team full time. Like we do use it but it's consultation and you do provide a service but I think it would be great to have it more integrated into the team so there's a mental health staff member providing the service with obviously training in the dual diagnosis.*

Service-users again reiterated the importance of a coordinator to facilitate the integration between services and information on available services. Participants also said that the services that they could now access ought to be available throughout all of the local mental health services. In the development of this theme, service-users reiterated the need for all related services to be interactive, where a coordinator established this interacting link. For service-users, the data illustrates that care needs to be coordinated and not compartmentalised to ensure sustainability. Participants also said that ideally services ought to be available on a wider scale and that dual diagnosis services should be a regular part of mental health services.

Sub-theme 2: Coordinated services

***p.2.** i couldn't condemn anything of it ja know, i mean i think it's great that we do have both there, i mean mental health and dual, ya know what i mean ye're trying to help everybody and in a good way, because when you're looking at people with different addictions, i mean you're trying to help people mentally, J's trying to help them with the actual addiction,*

***p.3.** em well it's educated me into addiction and you know I would have had a lot of ...perceived ideas before what an addict was and you know what was out there for them or what help and you know that I've come to accept that everybody can be an addict*

***p.5.** I'd say I think eh it's very hard to say how they do it individually ja know but em with both of them combined I suppose it's em what helps me because ...I'd normally have never have eh assumed one could lead to the other or vice versa you know*

p.6. *but I think ja know like both sides should be talkin to each other I mean addiction and somebody else might be in em having mental problems an who are them people talkin ta you know what do people if I was talkin to someone in mental side of it like mental do they actually talk to each other*

p.6. *Y like that you'd be able to discuss ...what I'm telling you with another with the other person on the other side like if I was talking to you about addiction you'd be able to go and if you think maybe there's something wrong that I'm you should be able to go to someone else*

p.6. *it's coordinated exactly that's what I mean both sides know exactly I just go along and either side of the room and you know what I mean. They look in your notes and its more balanced.*

Category 1.

Information

p.2*. it's the information about making sure that like you know exactly where you're going and whatever, more information around what services are available if you need them, or how to get to em'*

p.5. *I I I suppose the the lack of information around it like. I I never knew anything about anything we could do in .... the help meself getting along you know until I went out there like.*

Sub-theme 3: Services and service availability

(a) Services

p.2. *honestly, the amount of help I'm getting out of it, like i shouldn't complain, i mean, i mean I'm getting a lot of help, at the moment i mean, to me like, like i never knew that i would be able to access like em the acupuncture, the group on the Thursday, going to TP speaking to the other F, em and now the the ACT, the em*

p.4. *there..there pretty fantastic to be honest because ...em...they do ...give ya every door open and options for you to see em people in TP to help ya with anxieties ...em...to go to AH for the acupuncture and i think their incredible what their doing and they really couldn't do no more ... not for me anyway it's myself has to push me*

2. Service availability

p.3. *em I don't think so I suppose I now think my children would have benefited from it but at the time I wouldn't have asked for it because I didn't know it was available or what was available or... because... I didn't know would I upset them more do more ...*

p.5. *eh no being honest like it's just that em about the durability of the thing I dunno how long ...you can really go ...dual diagnosis I suppose you can't keep going there indefinitely*

p.5. *Need to be a part of ... mental health services on a regular basis ...eh because ... it lowers anxiety, it lowers stress ...*

p.6. *em ...I suppose the only thing really my problem with it is em the work situation like I can't access it during evenings like if I was able to go ...to evening ones it would probably*

suit me better. time like the time is out for me like that's basically what I find is the problem accessing it for people that are working

p.8. *missing it some days...because of work. eh...i think the meetings, during the day are very difficult for people, eh especially if you're working, emm. I think it there should be possible a possibility that it could be, i know weekends are a bad, no one wants to work at weekend, or in the evenings* to *facilitate people who are working*

p.9. *need to be part of the mental health services*

p.9. *maybe do a bit of a buddy system as well. you know em I think that would be very helpful ...it would be helpful for the person doing it and it would be helpful for the person receiving it as well*

p.9*. to look at a wider scale like you know ...even if there was like so you could drop in you know like if there was if you knew there was somebody say from 2-4. three days a week where you could drop in ... you know or make an appointment and sit down and say... you know somebody give you time listen to you ...and see what suggestions they could make you know encouragement and support for me around what I was doing the addiction but information and ...kind of encouragement then about the mental health side of it*

Permeating the sub-themes in this analysis was the identified need for training for healthcare professionals working with dual diagnosis, including the psychopharmacological effects of dual diagnosis and the role medication may have on an individual's wellbeing. Expressed desires for education also emerged from the service-users perspective, including subjects of relapse, medication and diagnosis, which participants believed would be helpful in their recovery process. Further, participants also expressed the need for education in these related subjects for family members and carers in terms of their supporting role in recovery.

Theme Two: Impact of unified services

Overall, healthcare professionals felt the dual diagnosis service worked well as it facilitated and supported joint working between professionals, with both mental health and addiction issues addressed simultaneously. This development they said was positive, though disintegration remains so in other neighbouring sectors. Service-users could now access numerous services associated with these two main services, including, acupuncture, mindfulness, art therapy, individual nurse therapy, individual addiction counselling, individual and group psychotherapy. Access to these services enables service-users to take an active role and responsibility in the management of their care. This indicated transference from being service dependent to service-users. In terms of family members and carers, key

workers nominated as a point of contact, was perceived as creating a link between the various services provided. Healthcare professionals believed that this was beginning to work well and would lead to better outcomes for service-users.

Sub-theme 1: Integration

The experience of the integration of existing services and access to a broader range of services for participants was benefiting individuals engaging in the service from diverse perspectives.

p.10. *I think it brings together the both the mental health and addiction services. It's seen as a bit of a supportive role as well. Previously you might have worked in isolation with people who were suffering from both mental health add maybe addiction problems*

p.10. *certainly having the dual diagnosis service benefits us and certainly is a support to our services and what we can offer to someone who is suffering from a dual diagnosis.*

p.10. *I think they are able to access a broader range of services then if they were attending either if they were attending an addiction service in isolation or a mental health service in isolation.*

p.10. *I would have heard previously from working in the group that clients feel that it is more round... that they don't have to attend two separate areas that they are coming to one service in particular and that helps people/families feel more supported*

p.10. *I think the dual diagnosis is more supportive and its certainly access to a broader range of services available instead of attending one in isolation.*

p.11. the *fact that we're able, you know, to address the problem at both angles in my view, clearly, leads to better outcomes.*

p.12. *the clients and the carers benefit because they are a catch it group that mostly can avail of both myself being a mental health nurse and addiction counselling*

p.13. *I suppose in my own experience people that I've worked with or that have been attending yourself on a one-to-one or through the group, you know, are able to address those specific issues in that setting and have that additional support around whatever mental health issues that they have.*

p.13. *I suppose if they had a good relationship with our service they are probably more likely to engage well in that group I would imagine.*

p.14. *so I suppose from that point of view from their loved one would benefit from the service so in turn they get help*

p.15. *It does, because if the person is referred to (am) the dual diagnosis services it's more co-ordinated care. There's a better linkup between mental health and addiction.*

p.15. *you find that a lot of them that would have a dual diagnosis aren't admitted as much but before they could be, you know say, in A&E every week, and they would be referred onto the unit, whereas now that doesn't seem to be happening as much.*

p.16. I *suppose there's the opportunity to do joint work with the staff in the dual diagnosis service*

***p.16. I** suppose people have benefitted from the dual diagnosis group because, I suppose, it's looking at both addiction and mental health issues rather than them separately.*

***p.16.** Well I think (pause) firstly I think they are recognising as having dual needs around their addiction issues and needs around their mental health and they are being looked at together, rather than being looked at separately and I think that helps people to cope better with their difficulties and for families to manage and understand their relatives difficulties better*

***p.16**. I think service-users get a better service and family members because it's in existence.*

***p.17.** in terms of being able to actually talk about their whole situation.*

***p.17.** Ok I'll put it this way they come from being service dependents to being service-users. They go from being people who are there to be helped to people who actually grow to look after themselves.*

***p.2.** the people were quite supportive, giving us the tools to help to deal with things you know, and that's the impression I get, that's what helps me I kinda think well you know if I wasn't doing that on a Thursday morning what would I be doing*

***P.2.** I don't think there's anything really, i couldn't say there's anything really, you know from the help I'm getting, i couldn't condemn anything of it ja know, i mean i think it's great that we do have both there, i mean mental health and dual, ya know what i mean*

***p.3.** em ... I suppose initially it would have been the extra things like the acupuncture and the tai chi and all that where i did find good benefit from the acupuncture*

***p.3.** I don't know how well ... one would do without the other*

***p.3.** and certainly, for me with the group and the counselling and everything but then having my psychiatrist who is ...i suppose a bit more from a medical point of view rather than a social or talking point of view that it's you know I'm getting the support from both sides'*

***p.3.** I suppose I'm more aware of triggers and I'm trying to cope managing better my coping skills have or (indecipherable) my coping skills*

***p.4.** because for the first time in my life both of the needs are been seen as one like ja know what i mean which is fantastic because. It's like ah this is amazing I'm being recognised as... a mental health patient as well as an..an addict*

***p.5.** to find all the different aspects of it being spoken about out there you know and I've no bother parts affect me and parts that don't affect me ja know being that dual diagnosis is both mental health and addiction you know it's just not one or the other*

***p.5.** I'd say I think eh it's very hard to say how they do it individually ja know but em with both of them combined I suppose it's em what helps me*

***p.8.** eh my whole life changed, if I hadn't been referred to the dual diagnosis services i would be back in (MHU) or dead*

Sub-theme 2: Service ambivalence and ambiguity

Participants believed the dual diagnosis service was ambiguous/unclear concerning access to services via two mental health sectors only, and negatively viewed as a disparity in treatment

provision. Healthcare professionals' also perceived stigma and negative opinions remained amongst staff, particularly towards individuals with a dual diagnosis, which they said may negatively influence the care delivery process. Moreover, these participants said that their lack of knowledge/information and skill base on the subject of dual diagnosis, may negatively influence how healthcare professionals work with and may be ambivalent towards those presenting with dual diagnosis.

p.12. *They have come in with a mental health issue, perhaps suicidal, under the context of alcohol or drugs and I have literally heard (am) health professionals (pause) say they have to deal with their addictions first before we see them in a mental health field.*

p.17*. I think (pause) the stigma, the whole taboo, the ghost of the past idea around addiction, mental illness or whatever.*

p.1. *...I suppose the...the addiction probably looked at a bit more than the mental health' 'They probably could look at mental health a little bit extra*'

p.6. *'em ...I suppose the only thing really my problem with it is em the work situation like I can't access it during evenings like if I was able to go ...to evening ones it would probably suit me better'*

p.7*. I think, in my opinion, that there is not as much recovery based solutions in it as there should be, even though the positives are there,*

p.7. *I can't really explain it, there is just something missing, I don't know if there is a one-to-one basis afterwards or anything, it's just kind of there is not enough fellowship being shared there, do you know what I mean. But I also think that maybe once every fortnight or once a month to have something on the wall that has the information, if you're in the Group that you can check afterwards...*

p.8*. missing it some days...because of work…*

p.9. *em. you know encouragement and support for me around what I was doing the addiction but information and ...kind of encouragement then about the mental health side of it*

Sub-theme 3: Education and training

Relevant to the sustainability of current services, participants stated that education and training for all healthcare professionals was essential in order to effectively to work with dual diagnosis in the long-term. Participants expressed the desire for service development to extend to all geographical sectors of the city, suggesting that this may contribute to the service's sustainability. Participants highlighted the need for designated staff including an addiction counsellor on each mental health team and the need of an individual to coordinate services on behalf of the service-user bringing about the integration of these services was critical to the delivery of care and to sustainability.

p.10. *would be rolling out more education to staff in the areas that are able to refer to dual diagnosis service. That staff are aware of the kind of personnel or kind of clients that would be suitable to be referred or that they might need some advice on*

p.11. *I do think there is a slight, (confusion) there is somewhat to do with regard to education and advertising dual diagnosis I do think it is being neglected here (am, am) so I see lack of knowledge perhaps in other areas,*

p.11. *I also think there's a role for psycho education about the importance of the dual diagnosis approach.*

p.12. *the education of the nurses and I include myself needs to be improved as well. I feel more support for staffing levels here to sustain it. This is a long-term support that's required so really funding for more staff and to develop more integration also and even to provide more service in education……. and more workshops that perhaps that could skill people to deal with the day to day issues with addiction and mental health.*

p.12. *the education of the nurses and I include myself needs to be improved as well*

p.12. *I feel very strongly that the nurses aren't skilled into providing support for that person through that acute phase. I think education is paramount in nursing and it opens people's views to accepting these people as clients as having a dual diagnosis rather than just someone in there with a mental health problem.*

p.12. *so really funding for more staff and to develop more integration also and even to provide more service in education*

p.14. *I suppose the information for me would be to find out more about the service. I suppose I attended the addiction... there was a kind of an in-service day a few weeks ago about (am) just training up on addiction assessment and that was a really good insight into I suppose as well as dual diagnosis and addiction so I suppose these kind of training days would be very good.*

p.14. *I suppose the lack of information from my own personal, kind of, experience I wouldn't know who I was referring to. I suppose the information for me would be to find out more about the service*

p.15 . *because I don't have the skills to actually to be able to confront them about, you know, their problems.*

p.15. *I personally don't have, you know, experience or skills to deal with a person of dual diagnosis….so if I had some training with regards addiction I think it would really help.*

p.17. *the need for education makes in this area. There is a need for a workshop that you can have around this and there is a real need for what can work and what will work.*

p.15. *I suppose if you actually had a co-ordinator that could link between all the different services: mental health, addiction and follow their care so that, you know, somebody wouldn't be at risk of, you know, of falling through the gaps. Whereas if you had a co-ordinator, you know one person is taking care of all that*

p.15. *it does, because if the person is referred to (am) the dual diagnosis services it's more co-ordinated care. There's a better linkup between mental health and addiction.*

p.16. *I think staffing is probably a big issue for the service and I suppose training for people around dual diagnosis is probably very important for the NBT. More training and more professionals working in that area, in dual diagnosis. you know, we need to meet all people's needs rather than meet one area.*

p.12*. it's the confinements of the areas of the localities that I find the biggest thing – I'd like to work more broadly. And the benefits I have seen in the short time I have been there would be evidence in that. So cross-section-ally I would like to see more work and more funding*

p.14. *I suppose am.. I suppose that it's important that the service is supported from different..., I suppose, (pause) that it's recognised and it's important that it is an issue, a big issue within mental health service as well and maybe more widespread and more recognised.*

Participants perceived the development as supportive, facilitating understanding by professionals involved, particularly within the individual counselling and group psychotherapy work where honesty as a value emerged as important to participants. Having awareness and access to a multidisciplinary team was enlightening for some, as though this may have been available previously; many participants said that they did not know that. Where the same group of professionals, on the same teams, was responding to both mental health and addiction diagnoses was perceived as user-friendly. Service-users also said that knowing about what services were available was great, though their greatest challenge can be in getting themselves there.

For current service-users' factors which limited the delivery of integrated services was the unavailability of services after 5pm and at weekends, particularly for those who worked or attended education resources. These participants also believed the lack of support from individual multidisciplinary team members was affecting the delivery of integrated services, and that some professionals lacked skills and knowledge on dual diagnosis. Concerning general educational support, some participants said that more emphasis seemed to be placed on substance use risks and behaviours, than on related aspects of their mental health.

Summary of findings

This Cycles **plans a, b, c** and **d** were outlined in this chapter's overview section above (p.163). Considering these plans, the findings above demonstrate that implementing **plan a,** *imbedding dual diagnosis services into practice*, has enabled the integration of collaborative working to become routine practice for this group within this organisational context. Facilitated by the interim coordinator and other participants, what has transformed is that service-users have accessed multiple services/disciplines that were previously inaccessible, whilst

simultaneously participating as co-researchers in many cyclical processes in the Cycle. The findings also illustrate, that while much more is required for family members and carers of service-users, many have linked-in with a key-worker or the interim coordinator for support and information, which the healthcare professionals' data source group stated will continue to lead to better outcomes for this population.

Plan b for this Cycle, *develop the referral pathway protocol and the coordinating role*, was achieved with findings demonstrating that while this plan changed in practice, it thereafter became part of the larger service operational policy document, the development of which spanned Cycle Two and part of which continued into Cycle Three. Considering the findings relevant to this plan, the development of a referral protocol for dual diagnosis in practice, was transformational. As part of plan b, the coordinating role was further developed with the plan also being achieved in this Cycle. Though the plan for developing such was broadly described, the Cycle's cyclical processes helped shape the evolution of this role, the functions of which were similarly included by participants in the development of overall service policy document.

Plan c for this Cycle, *add individual interviews to data collection methods* was achieved, and illustrated above in the overall data analysis which includes verbatim excerpts from inquiry participants/stakeholders representing two sources: 1. current service-users, 2. the organisation's employees.

Findings also illustrate that **plan d**, *apply for additional resources,* was achieved through participants developing an application that was submitted to the organisation's management team in this Cycle. Tentatively planning for this action in Cycle Three, participants believed it was more appropriate to submit this application in this Cycle.

For participants, Cycle Two findings demonstrate that the dual diagnosis service was generally perceived as being directly supportive, with MDT practitioners who were seen by service-users as understanding and clear when illustrating local available services and other social supports. This they felt impacted positively on their overall health and wellbeing. Particular reference was made to the availability of individual and group acupuncture sessions, one to one counselling/psychotherapy, group psychotherapy, group relaxation classes, group mindfulness classes' and one to one nurse support.

However, findings also highlight the service-users dissatisfaction with the lack of those services available to them after 5pm on weekdays and on weekends. Also in terms of communication, the findings demonstrate satisfaction with the coordinator and nursing roles, though service-users stated there should be a more joined-up communication system between practitioners. Suggestions made included: all of those involved in their care ought to document each attendance/session as it occurs, ideally within one filing system and not in multiple notes/files in varying locations, within an existing system that appeared to be fragmented. This group believed such an integrated communication process would ensure the continuity of their care across disciplines and services.

The Findings demonstrated by all of the data sources highlighted education, psycho-education and information for families and carers as essential, so as to facilitate understanding of what the concept and nuances concerning dual diagnosis can be and the potential impact on individuals and families. All data source groups also highlighted the necessity for education and training for both organisational employees and service-users respectively, particularly in the context of nursing staff requesting education on addiction related knowledge, and for addiction personnel up-skilling on matters concerned with medication and serious mental health diagnoses. Findings indicate that current service-users were satisfied with some of the psycho-education materials provided to them in the community, though while also finding that psycho-education in the context of dual diagnosis did not take place with staff on the acute unit.

Cycle evaluation

The core research group did not evaluate the Cycle as an isolated or planned exercise in itself, which upon observation was probably largely to do with the dynamics/actions emerging within the Cycle that were initially signalled for Cycle Three. The consequence of this was that it was more difficult to demarcate where Cycle Two ended, and where Cycle Three began. However, evaluation took place where agreed consensus permeated the various interactions occurring within the participant groups. This included MDT meetings, the feedback processes to the core research group and other less formal meetings with stakeholders over the last few months of the Cycle. This evaluation process will take place in the reflective phase of Cycle Three.

Simultaneous structural/organisational changes

Various changes took place within the organisation over this Cycle, an overview of which is illustrated in Figure 13 here, followed by discussion below.

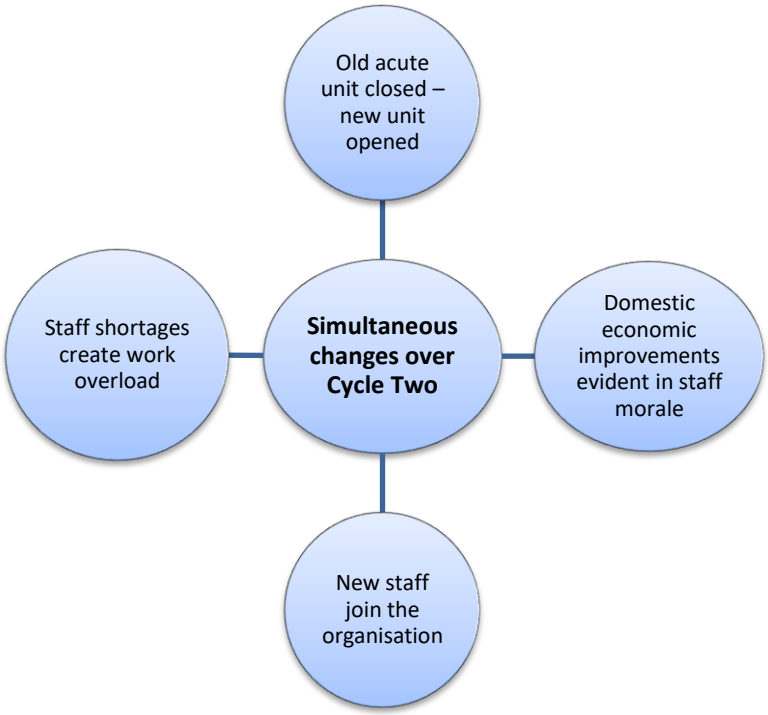

Figure 13. Map of simultaneous influential changes occurring within the organisational system over Cycle Two

While the hospitals acute unit is only one aspect of the overall service development, a significant structural change took place concerning this unit at this phase of the inquiry. As referred to above, the acute mental health inpatient unit of the main hospital (GF ward in the main hospital, CUH) closed permanently during Cycle Two, with the new purpose built unit (AAMHU) replacing it. However, its opening stirred some media attention concerning insufficient staffing numbers and other teething issues, though the bulk of dual diagnosis service-users (especially those with experience of the old unit/ward) and other participants utilising this unit reported positive experiences of the unit. This included individual rooms with secured wardrobes and lockers (one participant (service-user) said it was like a hotel), which the former ward did not have. Additionally, the older population were cared for on a

separate floor of the building, which participants saw as more suitable than the old unit was where the main socialising hub accommodated all populations. Such reports may have influenced the inquiry, though it is generally fair to say that participating service-users anecdotal evidence of their experience at this acute phase of the referral process (initial assessment and engagement with dual diagnosis team) appeared to be more positive about the new unit than that of the old one.

The stakeholder engagement - disengagement process illustrated above how the coming and going of staff had affected the inquiry process, while observing the organisational system more broadly; the system appeared to be structurally under strain because of staffing shortages. This was evident in how staff frequently started their shifts at least one hour earlier with many finishing at least one hour later than rostered. The impact of such practices over the course of the Cycle was that many staff became exhausted/sick necessitating sick leave that for many lasted several weeks. It was difficult to ascertain how this directly influenced the inquiry, though with ramifications of such either being unconscious or unsaid, the non-attendance of some participants as always seems to add additional workload burdens on others.

Theoretical insight: Prior to accessing our community services, many service-users engage with the dual diagnosis service via referral from the acute hospital setting. In this, upon receipt of the referral, the assessment process/phase of the referral commences. I and other organisational employees, in the context of dual diagnosis, access this phase of the service most days each week. Access to the new unit was easier than that of the old unit, for example, I did not have to walk through the emergency department (ED) and ground floor of the main hospital to see service-users and/or attend meetings. In addition, more meeting rooms are available in the new unit, which benefits efficiency all round. However, some organisational employees remain perplexed regarding car-parking, for example, the organisation's policy on parking states that in order to avail of free staff parking, an employee has to be a full-time employee of that particular hospital (CUH). For those of us whose organisational position (including the multiple roles I assume while participating in the inquiry) necessitates access to more than one hospital, in order to access this acute unit, public car-parking fees apply, alternatively, a free two-hour parking option is available in the shopping centre across the road from the hospital. Walking back and forth takes 25 minutes. The purpose built acute unit has underground parking where spaces have been sold to consultants working in the main hospital, with some of these rented annually to other staff. What concerns me is how this affects multi-disciplinary staff not employed permanently in the hospital and yet require access to this unit at least once a day. It is difficult to discern precisely if or how this affects the inquiry, though as staff continually discuss such anomalies, it seems reasonable that this scenario may affect how staff engage with the organisation, and thus with the inquiry, where access to this (acute) phase of the

referral process is at some level restricted by the organisation itself. In the middle of a busy day, I can relate to this restriction when parking across in the shopping centre car park in winter, walking back and forth to the unit in inclement weather conditions, does not lend itself to facilitating organisational employees. Within and beyond the inquiry context, when the organisation does not support its employees at such fundamental levels, is morale affected? In addition, if it is, how does this impact on morale affect one's engagement with change initiatives such as this and not least their engagement with service-users?

Paradoxically, new staff joined the organisation in various departments, which seemed to signify a positive shift economically, indications of which were also evident generally across the country. Despite some working conditions appearing to remain strenuous, as the economy was beginning to turn, workplace morale seemed to improve. This was radically different from the country's economic downturn experienced in Cycle One, which suggested how pay cuts and subsequent poor work morale may have influenced participation in the inquiry.

Positionality

The inquiry process changed/deepened my positioning and my interpretation/experience of it in this Cycle in contrast to Cycle One. For example, my varied roles described above in Cycle One, positioned me as a *hybrid*-insider collaborating with organisational employees and service-users in this organisational context (Herr and Anderson, 2015, pp.45-46). Cycle One findings had demonstrated that participants assumed this was a research project I was conducting myself, however, in Cycle Two it was clear that participants saw the inquiry as '*theirs*' as opposed to '*John's*'.

The experience and observation of the processes occurring in this Cycle however catapulted me deeper into the leadership and related roles I hold within the inquiry, with active participation of other stakeholders seeming to have become routine practice in many respects. This to me was evident for example in the manner by which participants communicated with each other and with me in collaborative situations. These included formal meetings where the reality of the dual diagnosis service was taking up discussion over the course of any week, and more informally, where participants were routinely discussing aspects of the service, as it was part of the overall mental health services. One concern I had though which I regularly highlighted during the Cycle, was that despite considerable progress, in terms of participation and with the embedding of developed services, there was still much reliance on my position/roles. Other participants were also experiencing over-reliance upon their roles

concerning the implementation and continuity of certain actions, which as we had highlighted in the application for additional resources, was unsustainable. Participants agreed that plans for Cycle Three would include this concern.

Perceptual framework with a developing practical theory

This Cycle included significant reflection in and on practice as the core research group developed the operational policy and some, though not all, service developments were embedded in practice. Findings demonstrated evidence of change, through the interactions of participants across the organisation, demonstrating the embedding of these service developments into practice had started. Many theoretical developments emerged in the Cycle from the actions that created them, including the development of the percepts: *the appeal of collaboration* and *is the organisation ready for change?* Here I illustrate two examples of how the initial practical theory was further refined within this practical inquiry. Firstly, the percept *organisational employee's buy-in* initially emerged in Cycle One, where it subsequently changed from the engagement, and disengagement of stakeholders in this Cycle. This occurred as many stakeholders had actively engaged in the earlier phase of the inquiry, others disengaged abruptly, disrupting the inquiry process. The effect was a shift from the initial percept from one where the organisation's employees had 'bought-in' to the collaborative process, to where stakeholder's engaged, disengaged or resisted participation based on what was subjectively perceived as appealing or not. Such collective dynamics led to the formation/emergence of *the appeal of collaboration* percept.

The second example illustrates how the indeterminate situation in view became determinate, with the initial practical theory modified in practice through its implementation. It can be reasonable to assume that from integrating the highlighted percepts into practice, the engagement of participants has increased by successfully embedding some of the service developments into practice. This has simultaneously occurred with particular resistance demonstrated by many participants/peripheral stakeholders, bringing the percept *is the organisation's ready for change?* into view. The identification of initial percepts and the initial practical theory emergent in this Cycle has come from the direct experience of participants engaging/disengaging and interacting with each other in the Cycle.

The introduction chapter describes systemic variance within the respective practice settings of addiction, mental health and primary care, which was followed by cited international best

practice recommendations for dual diagnosis including *the integrated model* (pp.8-13). While interpretations of the integrated model may vary from one context to another, the experience of implementing this dual diagnosis service through applying this methodological approach enabled the modification of emerging percepts to signify what the dual diagnosis service in practice includes.

In this, Figure 14 below illustrates further modifications of the practical theory within the practical inquiry framework. As participants in the core research group agree that the practical integration of percepts emergent from the evolving process, provides a collective impetus to participate in the further refinement of these percepts in practice. Where various organisational departments have traditionally operated relatively independently from one another, the indeterminate situation in view is the ongoing challenge of bringing about the cited inquiry aim of service integration. The process of realising this aim is iteratively occurring within a politically hierarchical organisation where remoteness from or dis-integration between services/departments has historically been the status quo, particularly in the context of dual diagnosis service provision (MacGabhann et al. 2004, 2010). These organisational realities were evident in this Cycle, through diverse levels of stakeholder engagement, and where organisational power dynamics may have influenced resistance to the inquiry/service development process. The perceptual framework below, indicates that engagement and resistance are relational in terms of participation and power, particularly where *the appeal of collaboration* percept embodies the engagement/disengagement or resistance of stakeholders. The refinement of this percept within the collective inquiry process has brought *the organisation's readiness for change* percept into view. However, as these percepts are further refined, either individually or through the amalgamation of more than one, the perceptually-evolutionary process continues to shape the service required, whilst naturally spiralling into Cycle Three.

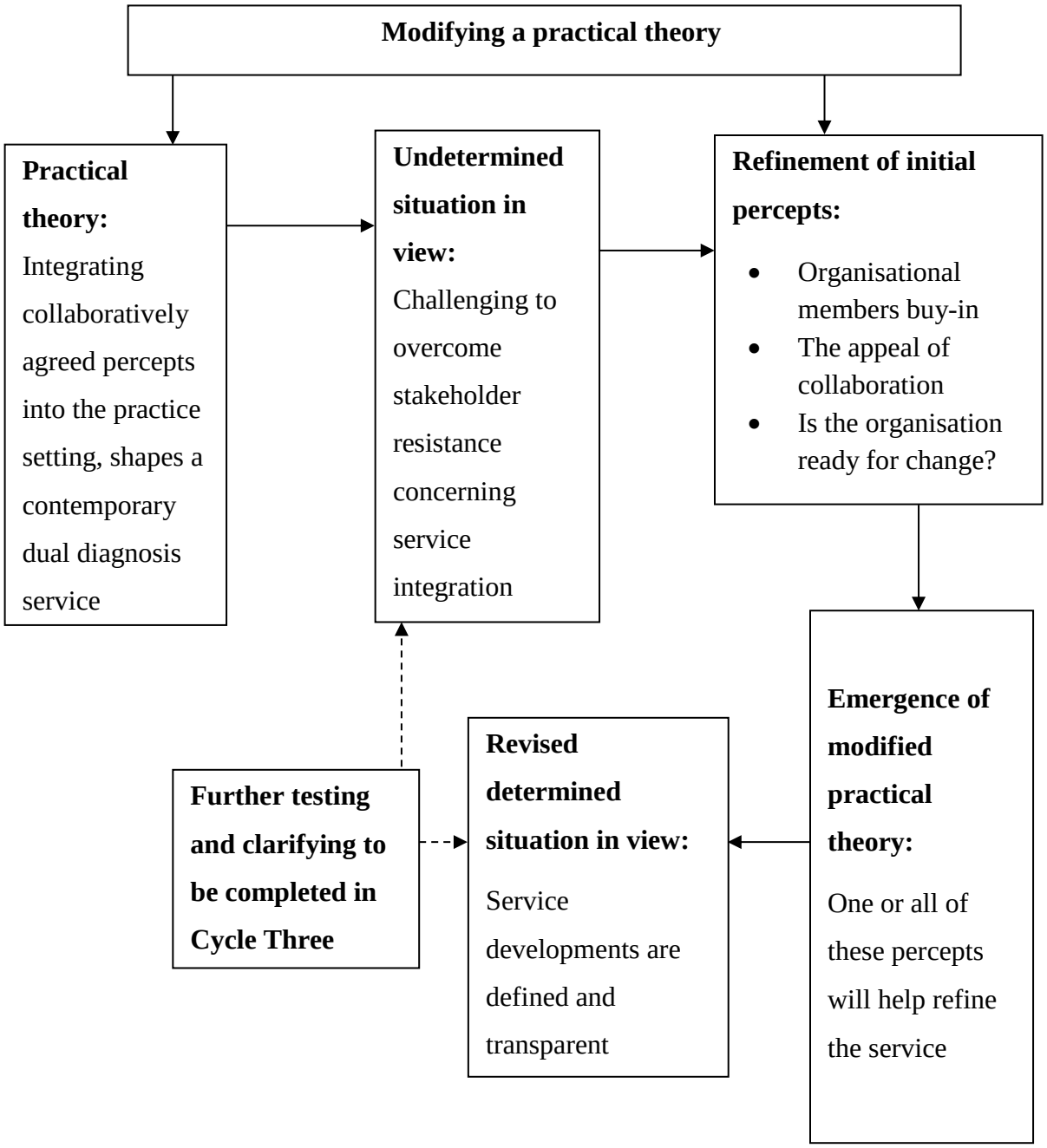

Figure 14. Illustration of practical theory evolving in Cycle Two

CHAPTER SEVEN: RESEARCH CYCLE THREE - EXPERIENCING DUAL DIAGNOSIS SERVICE INTERGRATION

The service developments which were initially established in Cycle One were further developed and integrated into practice over Cycles Two and Three. From this, the original percepts were further developed as the service transformation process became apparent across the organisation in Cork city and county. In this regard, as former individual percepts either ended or were amalgamated, newer ones also came into view. In practice this came about through diverse participant interactions, both inside and outside of the core research group forum, including all hierarchical tiers participating in finalising the operational policy document. With the Cycle's *ends in view*, all embedded service developments were implemented in practice, albeit awaiting formal approval from the organisation's area management team. (According to the organisation's administration department, this was frequently a lengthy process consistent with organisational procedures concerning the submission/approval of all policies submitted to management teams).

As an attribute to the participatory process (Webler et al. 2001, p.441), a renewed energy amongst participants seemed to instil an increased sharing of role responsibility than in previous Cycles. This was evident for example within the core research group who met routinely throughout this Cycle, and while participation had increased, engagement continued to fluctuate. Likewise, locum consultancy roles regularly changed, while knock-on effects of such did not adversely affect participation in this Cycle, as had happened previously.

The plans for Cycle Three were to:

> ***(a)*** *implement into practice, all remaining aspects of the service as outlined in the service's operational policy,* and
>
> ***(b)*** to *explore the experiences of the new service from the perspective of service-users within two case studies*.

These Cycle plans are introduced here.

(a) The development of the *dual diagnosis service operational policy* document took place in Cycle Two, while implementing many aspects of the overall service continued in this Cycle as in previous Cycles. Before the policy document was completed, core research group participants agreed that the continued implementation of service developments would continue where possible to include the active participation of all of the organisation's hierarchical structure. From this, where findings from Cycle Two demonstrated participant resistance concerning *the application for additional resources*, findings from this Cycle demonstrated increased participant participation both within the core research group context and in actively implementing aspects of service development in community and hospital settings.

(b) *The experiences of the new service from service-users' perspectives* are presented within two case studies, the approach to such included semi-structured interviews and reviewing participants' case notes. However, in contrast to service-users' interviewed in Cycle Two who had experience of the service at that time, case study participants had accessed general mental health services prior to the inquiry (when no dual diagnosis service existed), and had engaged again during Cycle Three (when the service was established). Within the inquiry context the experience of these participants was limited to Cycle Three, though their experience of mental health services prior to the inquiry enabled them to reflect on that prior experience also. Excerpts from the participants' testimonials presented within both case studies illustrated the transformation of the dual diagnosis service in practice. The interviews were conducted and transcribed by me, with the analysis conducted by the core research group as in previous Cycles. Participant observations and stakeholder interactions throughout the Cycle were collated in field notes/journals, references to which permeate the chapter.

Data from participant observations identified a gap within aspects of the service in the hospital setting that brought about the expansion of that service. Participants including the ADON, one CNM III, two CNM II's and two staff nurses had not previously participated, though whose engagement in this Cycle was instrumental to that expansion of the service, processes of which are discussed as they happened below.

This chapter illustrates the extent to which the inquiry/service has evolved in Cycle Three, though as an ongoing process some of the Cycles outcomes contribute to the planning phase for the next Cycle, of which are not included in the submission for this dissertation.

Figure 15 below illustrates an overview of the elements that occurred within the cyclical processes in Cycle Three, from September 2015 to March 2017 (approx.). Following suite from Cycles One and Two, the structure and presentation of the Cycle was in accordance with each of the cyclical phases and inherent processes that occurred at that time.

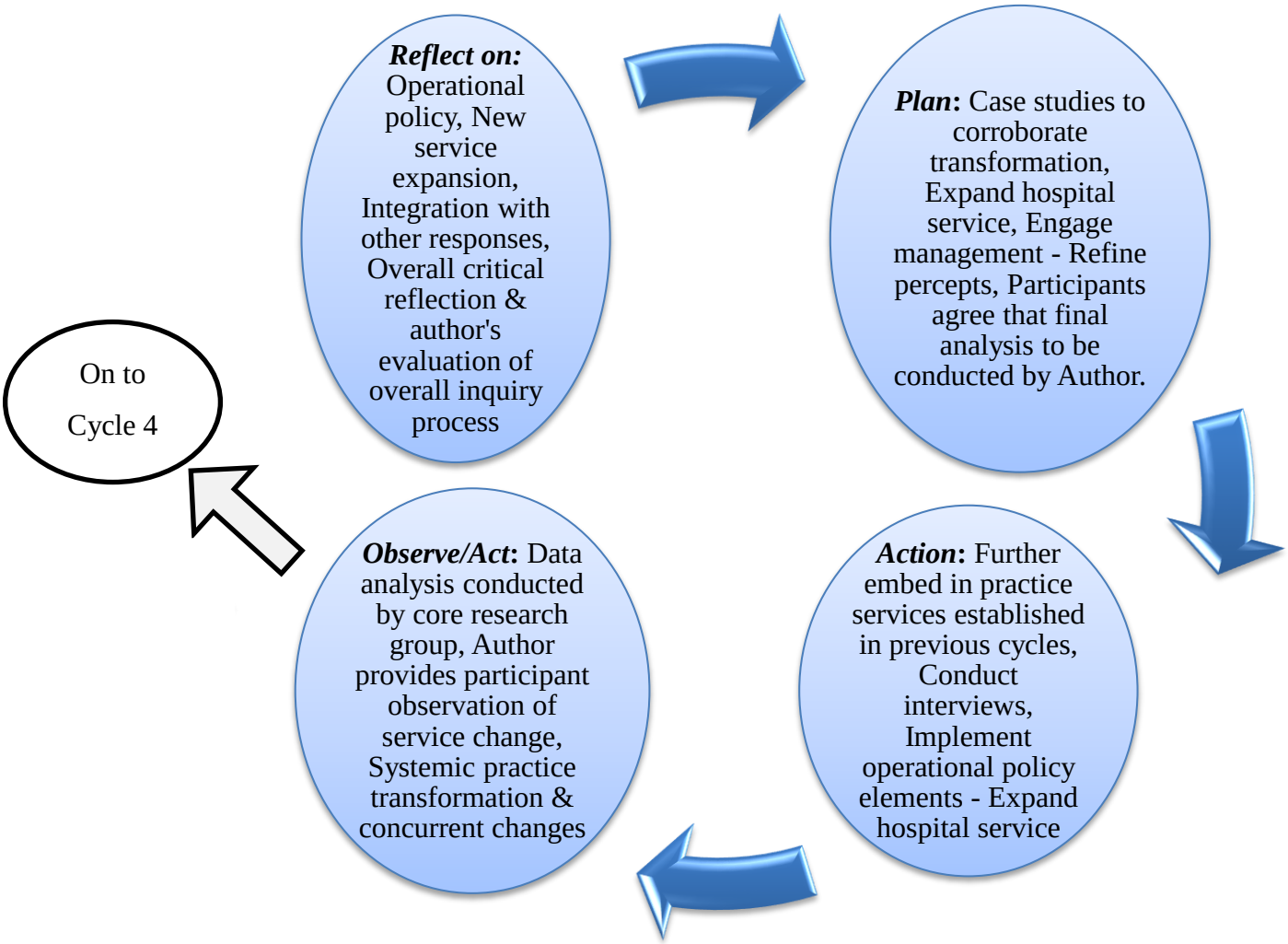

Figure 15. Overall cyclical process in Cycle Three

Reflection phase

Implementing the service in line with operational policy guidelines

Participants agreed that the core research group forum was critical to ongoing decision making and one which had evolved over the inquiry as an effective reflection group in action. This was particularly illustrated in this Cycle where various hierarchical levels of the organisation engaged with the core research group in finalising the service's operational policy. Figure 16 below represents such collective engagement, enabling individuals across the organisation's hierarchy to input documentary modifications relevant to particular disciplines/departments. It was mutually agreed that having all hierarchical tiers actively engaged, prospects of dual diagnosis service sustainability were increased. For example, where peripheral though critical participants had not responded to *the application for additional resources* in Cycle Two, because of increased levels of engagement in Cycle Three, participants agreed to re-visit the application later in this Cycle or in Cycle Four. On this basis, the core research group proceeded in developing stakeholder engagement in accordance to the identified ends in view from Cycle Two. In particular, participants acknowledged the apparent stakeholder shift from '*resistance to change*' to '*participating in the process of change*', a stakeholder movement that the core research group wanted to work with whilst collectively implementing the operational policy (Stonehouse, 2011).

While some of the established community and hospital based service developments had been embedded into practice in Cycle Two, embedding other aspects of the service continued in this Cycle. With regular core research group meetings, focus remained on the overall implementation process including email monitoring, formal/informal communication between stakeholders across the organisation's hierarchy. Outside of the core research group forum, it was frequently challenging to coordinate such intricacies, as participants held varying tasks related to the policy implementation process, some of which came about informally and undocumented. Further complications occurred with organisational employees taking leave, with others picking up the tasks (or not) in their absence. Ultimately, much of this flux became more orderly upon core research group reflections where responsibilities were re-evaluated.

Elements of implementing the service's operational policy as relevant to the particular cyclical processes of inquiry are discussed as they occurred in those sections below.

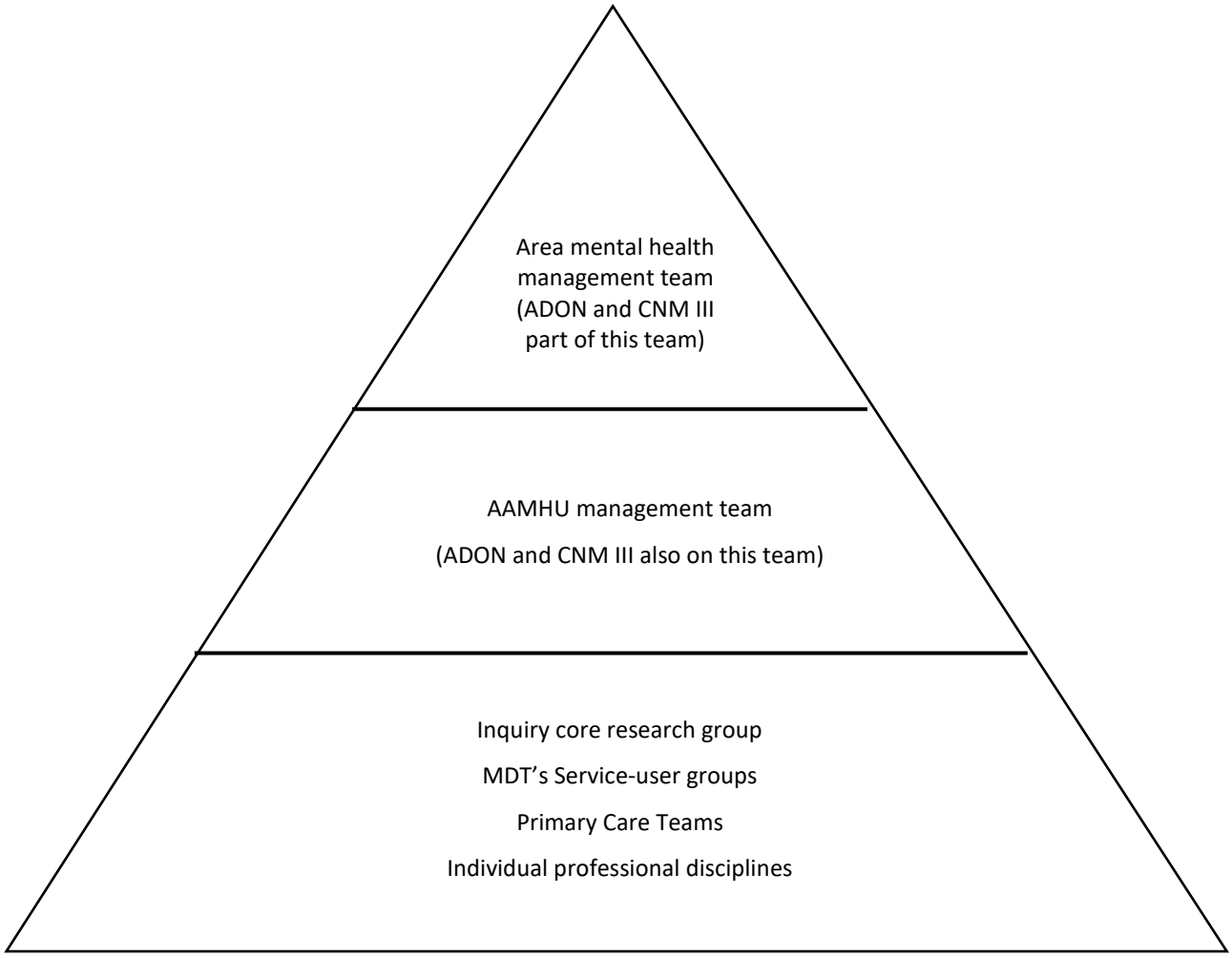

Figure 16. The organisation's hierarchical tiers participating in Cycle Three

Theoretical insight: The core research group invited all stakeholders to participate in the completion of the final draft of the service's operational policy document. Responding to the invitation, a CNM III (recently appointed) attended the core research group, signifying the implementation of the operational policy in practice was being taken seriously by all hierarchical tiers. The CNM III became the communication link between the core research group and the area's mental health management team for Cork city and county, where for example the submission of the policy document occurred via the CNM III. Importantly, whilst awaiting formal authorisation of the policy, the area management team, via the CNM III, communicated their collective support for implementing the service across all inquiry settings.

Where observations from previous Cycles demonstrated resistance in inquiry processes, levels of participation from across its hierarchical structure increased in this Cycle. In this, through ongoing and focused communication with all organisational tiers, the role of the core research group was instrumental in creating collective readiness for this organisational change (Armenakis et al. 1999; Raelin, 2012).

Such communication skills in and between participants were developed over Cycles one and two, though ultimately fostering an openness to dialogue within a communicative space where co-learning across diverse levels within the organisation became possible. Working with varied power relationships is consistent with PAR inquiries and reflected in organisational development literature (Argyris and Schon, 1998; Brockbank and McGill, 1998; Israel et al. 1998; Maiter et al. 2008).

Reflections on expanding inpatient aspect of the service

Core research group reflections enabled new action plans/understandings to emerge in this Cycle, where field notes data identified a service provision gap within the inpatient service. As the service was being developed solely on existing organisational resources, the inquiry was confined to two HSE sectors which inevitably excluded the other remaining six sectors in the local geographical area. In terms of generally accessing the service, such exclusion criteria whilst restrictive in community settings, posed little concerns over previous Cycles. In this Cycle, participants noted that because of such sectoral restrictions, individuals in the acute hospital setting were segregated in accordance to their home address. On this basis, the unit's management team requested that the service be expanded on the unit to include every patient experiencing dual diagnosis.

Reflecting on Cycle One service developments, the dual diagnosis assessment process started as early as possible on the unit with a view to creating the link with the community service (pp.150-151). This continued routinely in Cycle Two, while participants in this Cycle agreed that the impact on individuals from the segregation that the sectoral divisions had created, ought to be addressed. This was on the basis that the potential impact on people not having

access to dual diagnosis interventions on the unit included: relapse into substance use on discharge, non-engagement or limited engagement with community mental health services and potentialities of self-harm.

In addition to sectoral concerns, participants highlighted further understandings that may have influenced the service provision gap that led to expanding the service, including: acute unit staff being either unaware of the service or how to refer into it (which was a finding from Cycle Two), and the frequent turnover/short-staffing of mental health team members which seemed to blur communication processes between stakeholders.

Arising from core research group reflections, the service was expanded on the acute unit, the phases of which are discussed in the relevant cyclical processes below as they occurred.

Reflections on integrating with other local responses

In response to people presenting with dual diagnosis at specialist addiction services and at various mental health services in the Cork city and county region, some of those services had recently added DBT (Linehan, 1993a; Dimeff and Linehan, 2001) programmes to their menu of services in order to respond to local demand. The acceptance/admission criteria for these skills based programmes appears to vary from one location to another, though service providers say that these DBT programmes and adaptations of them in particular contexts are suitable for those presenting with dual diagnosis. As the emergence of these programmes locally, coincided with the time period of this inquiry, some participants in the inquiry requested and commenced assessment for one of these programmes, with the objective of learning DBT skills as part of their overall recovery plan.

The literature review chapter above discusses conceptual variations pertinent to dual diagnosis as being relevant to the philosophical, clinical, or methodological approaches of the particular treatment/service provider (pp.51-55). In this, the emergence of skills based programmes such as DBT locally responding to the complex needs of those experiencing dual diagnosis, can only be a positive development when seen in the greater context of service provision for this group. Furthermore, as some of the inquiry participants engage with such local programmes, our collective level of service integration has broadened across the organisation, as service-users have their complex needs responded to through multiple services and disciplines or departments.

Where such programmatic responses continue to emerge for this cohort, this can only help open up lines of communication between service providers and improve the quality and access to services for this group generally across the organisation and other community based services. Albeit a localised response, this is somewhat encouraging, considering the historical models of intervention in Ireland and the current impasse of the Irish government's policy development concerning dual diagnosis (MacGabhann et al. 2004, 2010).

Planning phase

Case study planning

Similar to Cycles One and Two, much of the planning for Cycle Three emerged from core research group reflection processes whereby findings and new understandings informed plans in the form of actions to take place. Within this, plans for this Cycle included two case studies to illustrate the experience of the new service where data from case notes and participant interviews would corroborate the transformation that was taking place. Participants agreed that findings from interviews conducted in Cycle Two had effectively informed decision making. Building on this method and approach, core research group participants agreed that as a means of validating the practice transformation, service-users that had experienced the organisation's service provision both before this service was in place and their experience of the service in Cycle Three, would be invited to participate in the case studies. It was further agreed that outcomes from these interviews would become part of the evaluation of the overall inquiry. The interviews were planned to be recorded and transcribed as in Cycle Two, with core research group participants agreeing to analyse all the data on an ongoing basis, though with particular focus on corroborating the transformation process.

Planning inpatient aspect of the service

Data accrued from field notes and participant observations, demonstrated that participants requested the expansion of particular dual diagnosis initiatives on the acute mental health unit (AAMHU) in this Cycle. As discussed, unit managers requested that dual diagnosis services be accessible to individuals from all sectors while in acute hospital care. For example, the CNM III stated that '*all patients should have access to dual diagnosis interventions directly while on the unit and in their preparation for discharge to relevant community services. It's important that this is part of the mainstream service, you know on a regular weekly basis. If*

someone comes in Thursday, Friday or over the weekend they must have had dual diagnosis interventions before discharge, which is often within a week to ten days'.

Planning to expand the service started when the mental health management team were invited by the core research group to participate in the completion of the service's operational policy document. Through this collaboration the service provision gap was identified with participants including acute unit personnel planned the intricacies of extending the service. The active engagement of the local mental health management team and the management team of the acute unit in this planning process, simultaneously signified initial steps towards formalising the dual diagnosis service. In this regard, the operational policy document (Appendix J) outlined all aspects of the current service, the principle contents of which include:

Contents of *Dual Diagnosis Service Operational Policy*:

- *Purpose of service and operational guidelines*
- *Values*
- *Service aims and objectives*
- *Access criteria*
- *Assessment and engagement*
- *Features of the dual diagnosis service*
- *Staffing, roles and responsibilities*
- *Safety and risk management*
- *Training and development*
- *Quality, performance monitoring and service review*

Source: Dual Diagnosis Service Operational Policy: (Appendix J)

While planning to extend aspects of the service on the unit, participants agreed that all inpatients having access to dual diagnosis services on the unit was a positive advance in service provision. However, it was equally clarified that because of the inquiry/service development being confined to two sectors (1. *Togher/Ballyphehane* and 2. *Kinsale/Bandon*), upon discharge inpatients residing outside the two participating sectors would be excluded from community aspects of the service. On that basis, planning to expand the service on the unit included the collation of information of other services/resource supports for people being discharged to those sectors outside the inquiry context.

The proposal for the dual diagnosis service to be extended to those six sectoral areas outside of the inquiry context were outlined in the *application for additional resources* in Cycle Two (pp.186-187), which the area mental health management team had received at that time. In this, all stakeholders were made aware of what participants were capable of achieving in terms of implementing additional service developments within the inquiry context, while also highlighting the particular blind-spots concerning the continuation of care from the acute unit to the community areas for individuals living in areas outside of the inquiry's geographical context.

(On speculation if sufficient resources were to be released, the full range of dual diagnosis services that people now have access to in the two participating sectors, would be potentially extended to the remaining six sectoral areas).

The components of this embedded service expansion are discussed further in the *action phase* below as it occurred.

Theoretical insight: The interaction between the core research group and the organisation's management team locally was positive, particularly as communication processes over Cycles One and Two had been one directional (*resistance* discussed in Cycle Two). I was aware that the proposed expansion of the service on the unit was potentially a resolution to an ongoing problem for the mental health inpatient services in the context of dual diagnosis. Albeit unsaid, what seemed to be happening was that while awaiting approval of the service operational policy, the mental health management team supported the dual diagnosis service in general and their support of the additional work on the unit was equally positive in terms of their collective engagement with the core research group. This I believed was both a practical and symbolic response to dual diagnosis, which at this juncture was a cultural shift for the mental health services that historically have 'referred out/on' any concerns with addiction/substance use. However, while practical and symbolic advances are evident, what remains concerning is that all service developments continue to be implemented with the utilisation of existing resources. In the short-term (over Cycle Three), this puts further pressure on managing my own time/workload, though I was prepared to make certain adjustments in order for the policy to be further along the line towards formalisation and for the work on the unit to be expanded (Ravitch and Wirth, 2007; Coghlan and Brannick, 2010). However, while highlighting sustainability concerns beyond the timeframe of the inquiry, I planned to revisit the sustainability of this work again after some months, once we collectively had a better idea of what unit staff were willing to participate in the service expansion and in training. Also, after the additional work on the unit began, it was mutually agreed to reengage with the area management team concerning the application for additional resources in order to extend the full service to all sectoral areas (Cornwall and Jewkes, 1995; Appelbaum, 2015).

Percept focus and modification

T*he appeal* of *collaboration* percept permeated previous Cycles, in particular where it included stakeholders' engagement, disengagement and resistance to participation in the inquiry/service development process. In this, while the core research group maintained focus on the percept, its presence was modified further in this Cycle through deepening engagement with other stakeholders across the organisation's hierarchical system (p.220). In previous Cycles, stakeholders engaged, disengaged or resisted participation in accordance to what was subjectively interpreted as appealing or not. For example, Cycles One and Two demonstrated that service-users engaged, disengaged from the service and inquiry for varying time periods, which core research group participants agreed was consistent with general levels of engagement in public mental health services. While organisational employee participants engage differently with the organisation, for example, in an employment capacity, their engagement, disengagement or participation in the inquiry appeared to be influenced likewise by what aspects of the inquiry/service development were subjectively interpreted as appealing or not.

The active participation of managers from the area mental health and acute unit teams, demonstrated that *the appeal of collaboration* percept remained equally pertinent to this phase of the inquiry process. Regarding Cycle Three planning, as the core research group had engaged all hierarchical tiers in this dialogical process, the democratic approach to creating *organisational readiness for change* had moved from being aspirational to being visible in practice. As Raelin (2012) notes:

> '*People join a dialogue provided they are interested in listening to one another, in reflecting upon perspectives different from their own, and in entertaining the prospect of being changed by what they learn, often leading to collaborative action*' (p.9).

Further evidence that collaboration was appealing across the general service was visible where service-users were being informed by organisational members of the services available to them. Because organisational members had largely engaged throughout the inquiry process, service-users were benefiting from the employees' renewed knowledge of services, which many employees may not have known about prior to the inquiry process. For example, many mental health professionals frequently reported a lack of local knowledge concerning dual

diagnosis community supports, though from increased multi-level collaboration, stakeholders were updated swiftly with inter-referring/signposting having become more fluid. As this percept became more evident throughout the organisation and the broader social world, core research group participants planned to represent evidence of such collaboration through service-users' perspectives. These are illustrated within case studies that are presented in the *observation phase* below.

An emerging percept in this Cycle was *the invisibility of diagnosis*. At the initial point of entry, practitioners in their initial assessment screened for dual diagnosis in hospital and community settings. From screening, when a dual diagnosis was suspected, a referral was subsequently made to the service. From that point of referral, no further reference was made to diagnosis over the course of the individual's engagement with the dual diagnosis service. In this, diagnosis was ominous by its absence/invisibility in any planning or other discussions throughout the Cycle, warranting further exploration in the Critical Discussion chapter below.

Action phase

The action phase permeated the Cycle through:

(a) Further embedding into practice the services which were established over previous Cycles,

(b) Case study development, and

(c) The implementation of the operational policy. These actions collectively seemed to catalyse the transformation process that occurred in the organisation at this time.

(a) Further embedding of services established over previous cycles

As Cycle Two merged into Cycle Three, core research group participants agreed that Cycle Two's overall action objective, *to embed services established in Cycle One, into practice in Cycle Two,* remained relevant in this Cycle as some aspects of the service were embedded and others were not. Cycle Two findings demonstrated that access to and the development of new services had benefited multiple stakeholders, in particular service-users. Nevertheless, core research group participants agreed that the process of embedding various aspects of the new service could continue in this Cycle.

While such continued embedding was transparently planned for within the core research group, participant observations and field notes taken outside of that forum demonstrated that many participants (organisational employees in particular) were taking their engagement in

the collective process more seriously in this Cycle. An example of this was noted by a CNM II: '*it's about time to see DD clients being discussed as normal at the MDT meeting…. as part of the overall service, how long has this taken?*' What the nurse participant seemed to be referring to was dual diagnosis clients over the past four to five years were discussed/reviewed at the opening of the weekly MDT meeting. After such, I usually left the meeting, while the team continued to discuss other mental health service-users. This had signified the MDT's and perhaps my own resistance to including dual diagnosis service-users as part of the overall mental health service, which according to the nurse's observation took until Cycle Three to see this change. In effect, the resistance (to participation) that had emerged in previous Cycles, seemed to have largely dissipated in our day to day delivery of services as Cycle Three got under way.

(b) Case study development

The case study approach (Punch, 1998; Stake, 2000) included interviewing service-users that had experienced the organisation both prior to the inquiry and again in this Cycle. In planning this Cycle, invitations to participate were positioned in organisational locations frequented by service-users. From this, there were six service-users whom core research group participants believed had this unique experience. No service-user made contact from the adverts, though from discussion with other participants two agreed to participate in the case studies. Forming part of the case study approach, the interview questions were designed by the core research group, the interviews were recorded and transcribed by me, with the analysis continuing to be conducted by core research group (Gubrium and Holstein, 2002).

Both case study participants demonstrated varied experience/engagement with the organisation's respective mental health service locally and addiction service's locally/nationally, within the specific context of their subjective experience of dual diagnosis and the organisation's dual diagnosis related services which were made available to them in or before 2011 and also in 2016/2017.

(c) Continued implementation of services, stimulating service expansion

As discussed, the collective development and implementation of aspects of the service spanned previous Cycles, and continued in this Cycle, whereby participant observations (at core research group meetings, MDT meetings and also in less formal settings including the hospital canteen and the community centre's kitchen) were reflected upon. This invariably

brought forth new action plans where personnel/participants on the acute unit wished to improve/expand this aspect of the service concerning the dual diagnosed population on the unit. In this, the proposed resolution to the previously discussed sectoral concerns were illustrated in the operational policy, prior to implementing these in practice. The participation of the unit's management in this negotiation/implementation process, was instrumental in authorising the expansion of the service on the unit.

Theoretical insight: Even though there was now a direct link with the organisation's area management team, via the CNM III and the ADON for one of the participating sectors who was based on the unit, the process of formalising the new service within the inquiry's timeframe was quite challenging. Some of this was evident in transparent communication processes between stakeholders which is discussed in the particular phases of the Cycle, though at the same time there appeared to be some subtle undercurrents of resistance at times which to me were represented in periods of silence and non-communication from participants concerning our proposals. Despite making acknowledged progress in completing the policy and implementing many of its outlined guidelines throughout the inquiry process, I couldn't help feel at times as if the core research group (including many participants/employees/service-users) were trying to sell something to higher tiers of the organisation that they either knew nothing about or that they were disinterested in. Yet it was widely and publicly acknowledged (in literature already referred to in the inquiry process) that clinically, dual diagnosis was an ongoing problem for acute mental health services internationally. Though it was also clear in this inquiry process, that no evidence existed of these local mental health services actually doing anything meaningful to rectify this problem. Importantly, while acknowledging recent progressive shifts in participation, when inquiry participants from within the community mental health and primary care addiction services approached the management of the hospital's acute unit with a view to expand that aspect of the dual diagnosis service in very specific and sustainable ways, engagement while tedious, enabled the service development to begin.

As the planning-in-action phase of expanding the service on the unit was taking place, this involved core research group participants developing a proposal of what it would include and negotiating it's components with relevant stakeholders. This included a focus response to all dual diagnosis inpatients on a weekly basis on the unit, necessitating two participants from the service, one nurse and one addiction counsellor. Elements to include psycho-education, one-to-one support, group therapy, the updating of notes and audit input, which was proposed to take one full day each week. As the management structure of the Togher/Ballyphehane sector's mental health team functions independently to the management of the acute mental health unit, the CNM II on the community team refused to 'release' the nurse for a full day's work on the unit, due to workload in the community.

The other sector participating in the inquiry, Kinsale/Bandon, by their lack of response to this request, refused/resisted the releasing of any personnel from the community to participate in this work on the unit. Even though acute unit management, with support from the area's mental health management team, approved the overall service and proposals to expand the dual diagnosis work on the unit, there was no indication that any nursing staff on the unit were prepared to participate in this service expansion at this stage. Furthermore, core research group participants agreed with the unit's CNM III that at the negotiation stage, asking nurses on the unit to do any extra work in this regard may further hinder any progress of implementing this initiative. Through negotiating and working with this resistance (Self, 2007; Stonehouse, 2011, 2013) from within various levels of the management structure, four hours was collectively agreed to in lieu of the full day proposed. Also because of the organisation's sectoral divisions, management in one sector expressed difficulties in releasing staff from that team to work with service-users from other sectors on the unit. Considering such nuances and in order to begin this important dual diagnosis service expansion on the unit, it was mutually agreed to begin this intervention with service-users from all sectoral areas. However, for those living outside of participating inquiry sectors, upon discharge, access to dual diagnosis interventions occurring in Togher/Ballyphehane and Kinsale/Bandon areas would be compromised. Of note, the planning process from Cycle Two had included the application for additional resources with a clear rationale and objective concerning the bridging of this sectoral gap in dual diagnosis service provision locally.

Theoretical insight: While at various managerial levels the organisation struggled with implementing/expanding the new service especially in relation to releasing staff to sustainably support the change - from a cultural perspective it was equally evident that the organisation was embracing change. For example, this change was particularly evident whereby the pre-existing culture of 'closed/fixed sectoral working' was certainly within this service development/inquiry context altered to that of 'cross-sectoral working'. This was visible on a day-to-day basis over all three Cycles where participants from the two participating sectors, i.e. Togher/Ballyphehane and Kinsale/Bandon actively collaborated in many aspects of the inquiry/service development. Likewise, with the service expansion on the acute unit in this Cycle, management's participation and approval of the new service demonstrated this cultural shift towards sustainable cross-sectoral working. Concerning such organisational change, Romero (2012) notes: '*implementing change requires participation from multiple stakeholders including those engaged in planning through to implementation*' (p.4).

Observation phase

The process of observation took place in various ways throughout the Cycle, through collective systemic dynamics and interactions between participants as the embedding of services continued. For example, participant observations and field notes indicated that participants continued to engage in community based individual/group therapy/counselling, relaxation/acupuncture sessions, out-patient mental health clinics, DBT programmes and core research group meetings, as these services became further embedded/integrated across the organisation and wider social system in this Cycle.

One of the plans for data collection in this Cycle was achieved as service-users described their subjective experience of the service development through individual interviews, as part of the two case studies conducted. Other participant observations in this phase included systemic and social factors, while co-occurring with this Cycle, may have had some influence within or from that co-occurrence and are discussed further below. As the Cycle was dynamic in many respects, the nuances involved with the ongoing integration of services was evident while implementing the operational policy, in particular how that led to expanding the inpatient service. Further, that participatory process in itself brought participants into working directly with senior levels of the organisation's hierarchy, instigating the initial formalisation/approval of the overall dual diagnosis service. These observations emerged from participant field notes and journaling, of which are reflected in narratives throughout the Cycle's write-up.

Cycle Three participants

The service developments that occurred in this Cycle were made possible by the participation of stakeholders representing all hierarchies of the organisation as illustrated in Figure 16 (p.220). The iterative process of service development included the maintenance of participant engagement over Cycles One (p.124) and Two (p.163) that collectively contributed to the additional participation of management in this Cycle. Over that eighteen month period (approx.), the process of implementing the service's operational policy enabled participants to experience the new service at this phase of development.

- Total number of referrals into the dual diagnosis service in Cycle Three 216
- 65% were referrals/re-referrals from participating mental health service sectors 140
- 35% were referrals from GP's 76

- Of the 65% MHS referrals, 64% came from the Togher/Ballyphehane sector 90
- and 36% came from the Kinsale/Bandon sector 50
- Of the 64% (90) from Togher/Ballyphehane, 72% were hospital referrals 69
- and 28% were seen at OPD 21

Monthly average participation in data source groups:

- Core research group 16
- MDT group 52
- Psychotherapy group 32

Service-user engagement fluctuated as in previous Cycles, though while attendance at the varying aspects of the service was regular, at face value overall participant numbers appeared to decline from Cycles One and Two. The core research group's rationale for this was that referral numbers were relatively high in Cycle One as referrers were referring into the new service. In Cycle Two these numbers appeared to stabilise as service-users accessed and disengaged from services as required. Stakeholders across the organisation and locality increasingly became aware of the service that had by the end of Cycle Three become routine practice, a consequence of which was the apparent stabilisation of service-user's engagement, and disengagement from aspects of the service.

As reflected in previous Cycles, these are average participant figures and cross-over regularly took place between groups as some participants may have participated in all groups in one month and maybe less so or not at all in the next. Furthermore, fluctuation occurred as organisational employees changed jobs, sectors and roles, and where some groups met weekly, others met monthly and the core research group for example met every six weeks.

Case study interviews and case notes review

In addition to journaling and field notes taken, the case studies and interviewing process also contributed to the Cycle's evaluation. For example, service-users in their descriptive testimonials illustrate their experience of the new service. Furthermore, excerpts taken from case notes illustrate documented interactions between mental health service personnel and the service-user prior to the inquiry, and interactions whilst engaging with the new service, which may inform future core research group reflections.

The case study objective was to illustrate the service transformation that had taken place. While illustrating such data was valuable in itself, it may also be valuable to others who may

not know about the new service. Findings likewise informed organisational members (new incoming staff) of the change in service provision over this time, as new staff also had not experienced the organisation prior to the existence of the new service. Central to the case studies, testimonial data provided further insight into how the broader social environment was benefiting from the new service, and in particular how people's interactions inside/outside the inquiry context were influenced (community nurses and GP's utilising the referral protocol).

Theoretical insight: This was an important insight for me, as my positioning in the inquiry context had me located very much within that. Having assumed many functions within the overall process and remaining embedded as a participant in the inquiry, my predominant focus was within the inquiry context and related organisational environment. The case study process including the review of case notes and data accrued from the interviews, collectively broadened my perspective on how the organisation and the wider social world in which it is located, was positively affected by the new service. Similarly, the interviews informed me how other services outside the organisational context (though integrating with the service) including for example general practice (GP's), have such an influential role in the short- and long-term care of those experiencing dual diagnosis.

Case studies

The case studies are presented individually. While data emergent from the Cycle were analysed collectively as in previous Cycles, for presentation purposes the themes emergent from the analysis are integrated within each case, thus the inherent discussion includes cross-referencing. The analysis discussion follows the case studies with an example of coding, categorisation of codes and emergent theme is presented in the appendices (Appendix I.).

Case study: One

Testimonial excerpts were selected from participant's case notes and from interview. The name Mary is fictional and was selected for narrative purposes. The abbreviation ***p.18*** was used to identify this participant in transcribing the recorded interview.

Mary had engaged with mental health services prior to the inquiry, from 2008-2011. In 2016 her GP referred her to the dual diagnosis service.

Participant details, prior engagement with mental health services:

Mary is a 27 year old mother of two children, a 4 year old girl and a 2 year old boy. Mary is currently sharing a two-bedroom apartment with a male partner, her son and his 2 children from another relationship. Her daughter currently lives with Mary's mother and has done so

for the past two and a half years. Mary is currently undergoing a drug detox supervised by her GP.

In 2006 Mary had an impulsive prescription drug overdose: Drugs taken - Paracetamol and an anti-depressant, the amounts of or name of anti-depressant were undocumented. In 2009 Mary took another overdose following an argument with her father, drugs noted, Mirtazapine and Lexapro. Amounts undocumented.

Case notes describe Mary being initially diagnosed with depression at 16 years of age and experienced post-natal depression following the birth of her first child. This she said preceded her first GP supervised detox in 2011.

From 2008-2011 Mary intermittently attended mental health services, where she was diagnosed with *anxious-depressive with emotionally unstable personality traits* at that time. After her initial hospital admission, her engagement with mental health services was sporadic.

> *'When I came into the services before I am (pause) I came through my GP and am... I went from there…but we didn't know anything about any other services to be sent to about all our problems kinda… well I don't think there was much talk about it anyway ya know…'*

Describing what aspects of the services that were made available to her at that time she said:

> '*While I was in hospital they told me I should be doing this; I should be doing that…. but you know I'd no interest whatsoever in art therapy or sitting in a room with ten other people going through these are the signs of depression. I mean hello like, I think I know, isn't that what got me admitted in the first place. Maybe it could have been helpful. Maybe I would have learned how to recognise I was in that downward spiral again. Anyway, while they said I should be doing this and doing that, nobody insisted I got my ass out of the bed. I was left there once I said no.'*

Regarding her substance use, the mental health services in 2011 had indicated what options were available locally:

> *'I was told that I could go and treat my addiction at Arbour House* (specialist HSE addiction treatment service in Cork city) *and I was to go to my follow up appointment 3 months after the day that I was let go… That was the extent of the services that was available to me in 2011….Like I said, the clinic to see the psychiatrist and the*

addiction services if I was willing to go, which I wasn't cos I didn't think I had a problem. Drink was helping me cope with my mood and it relaxed me and made me forget the crap that was going on in my life. So why would it have been a problem. It was helping me. Anyway they didn't understand that in the hospital or when I was discharged'.

Presentation in 2016

In 2016 (in Cycle Three of the inquiry) Mary was referred by her GP directly to the dual diagnosis service (demonstrating that the referral protocol was embedded), with particular concerns related to the ongoing detox process and extended depressive periods.

Theme 1. Experiencing the referral process

The initial theme emergent from the data analysis demonstrated Mary's experience of the referral protocol in action, whereby her GP directly referred her to the new service. Even though her GP was aware of the new service and of the referral protocol for some time, it is unclear why the referral had not been made sooner. However, considering the overall inquiry aims, Figure 6, Process Map A (p.150) illustrates how service-users accessed acute mental health services and what was available to them at that time (pre Cycle One) in the context of dual diagnosis. This service-user's experience of the referral process in Cycle Three demonstrates that practice transformation has occurred within the realm of the referral process.

Mary describes a deterioration in mood over the past 7-8 months, which she partially attributes to the drug detox process:

> '*I'm up and down most of the time, mind racing, look tis the same old story when coming off that stuff, jayzus with the kids and hassle with himself, I find it hard going*', rating her mood currently 4/10. She said she cries for '*every reason and no reason, sorry now like but I'm all over the place as you can see, you don't see me any other way do ya ….?* '.

Mary says that she cannot really pinpoint why she feels this low, but adds that financial stressors are also relevant:

> '*I'm kinda coping I spose, but I'm working away the few days inside town and I have to carry it all like, he blows it all and there's nothing said about it, ya know what I*

mean'. She describes being '*unhappy with all of it*' that she has to '*pay for everything*' saying she has little financial support from her partner, whom she says is a '*compulsive gambler*'… *When it does come up then like he says he'll get it sorted – the gambling like – but it's all promises, you know the story….*'At the present time she is unsure what direction her relationship will take: '*I dunno what to do with him …., after a row he's all promises he'll go to treatment, especially when I tells him I'm gonna walk away, but not a budge boy..(pause).he never does nothing.*'

Mary describes her appetite as variable:

'*I tries to cook for the smallies sometimes but I'm not great to be honest, look at the state a me look …., sure we'll do one thing at a time I spose …., they know me very well in the bloody chipper that's for sure ….*' Overall she describes her sleep as good, '*no problem sleeping …., tis getting up can be murder, I find the mornings hard especially with school an stuff, or if I've an early shift, though tis usually at 12 or 1*'.

Regarding thoughts of self-harm, she admits to currently experiencing fleeting suicidal ideation, but no active plan or intent, describing her children and mother as a protective factor:

'*at times I just wish me life was different, or if twas all over ya know, oh tis all crap at times boy … but no I've have no real plans like that, just the odd thought on the spur of the moment like, jayzus we had enough of that before …, when I thinks of the small ones, I'd do anything for them. Ma is great too she's like a sister to me really ….*' Her main concern presently she describes as being the reduction of '*my*' diazepam as part of the detox regime (i.e. 30mg diazepam - 5mg diazepam once daily), while experiencing guilt in relation to her alcohol consumption in the detox process, '*anytime I'm being cut down after a week or two I go back on the lash, then that's more hassle at home as I go over to the lads, ya know across the road in the flats, couldn't be arsed with the pub, but the lads over then always have a bit of the other thing, and back to the merry-go-round again, that's usually out all night or a couple of em, hassle with Mam, himself and then I'm fulla guilt ya know, oh god*'.

In contrast to what the organisation made available to Mary prior to the inquiry, she described her experience of the new dual diagnosis service in 2016.

'Yeah I ended up in hospital again this year. But this time it was different you know, while I wasn't forced to go to groups, I remember one nurse sitting on my bed and saying to me, I know you know what depression is, but maybe you'll benefit from the group, they still ran groups on the ward, by learning to recognise when things aren't going so good for you and you need a little extra support to avoid ending up in here. Why not give it a shot anyway? So I did and she was right I did learn a lot, especially from the others who were the same as me, I mean others who were depressed. While I was in hospital this time a guy called .... came to see me about my drinking, he's an addiction counsellor, he said that I had been referred by the psychiatrist to him because of where I was at cos of drinking, he told me after we were chatting for a while that there was this group held once a week for people like me who had both a mental health problem and an addiction'.

Theme 2: Experiencing service integration

The Introduction chapter overviews various organisational systems/services that individually and in diverse ways, respond to dual diagnosis. One of the overall inquiry aims was to develop an integrated approach to service provision for this group. Mary compared her engagement with the organisation's mental health services in 2011 (pre inquiry), to that of 2016/2017, in Cycle Three, illustrating how the integration of dual diagnosis services benefit her.

'Yeah totally different. While in hospital the staff couldn't really understand why I did what I did, they just saw it as too much drinking, a problem, but they tried to understand, but they couldn't, that's different to my last admission, the trying to understand bit. I think that's why I was referred to J… for the drink like. I think this made all the difference. You know both sides of my problem being looked at, mental health and addiction. Mental health staff looked at my depression and J… focused on my drinking, yet you know both of em are joined, both affect me at the one time, but both are looked at separately and this is frustrating cos there not separate. But at least I suppose both are looked at, which is better than before. Cos J… came to me when I was in hospital it made it easier to go to the dual diagnosis group. I'll be honest with ya it was scary at first cos I didn't know really what to expect. But you know from going there I now know that there are loads of people just like me. By going to the

group on the ward it really helped me in recognising when my mood was starting to dip. I even have a crisis and post crisis plan now for such an event…'

Mary describes how the mental health and addiction services functioned independently and in different city locations which was challenging for her in 2011. Today her complex needs are responded to from the dual diagnosis service in her own community.

'There's no comparison. There was nothing available in 2011. I was told, like I said earlier about the addiction services that were in a different hospital over in Finbarr's but I'm living in Togher. I'm living in a different part of the city. I was hospital in CUH – I had to travel all the way over if I wanted to go over to the addiction services. But am, dunno I was a bit paranoid about going over there and because I had a mental health diagnosis they couldn't really help me either. That was seen as my main problem and someone with schizophrenia couldn't get into any of the programs over there that time. Maybe it's changed now I'm not so sure. That's the way it was... in 2011 but now God I'm going up and I'm meeting a couple of the people above in Arbour House regularly and I'm meeting with J in the community. I'm meeting with all the other people on the mental health team. I'm sure they're on the mental health team anyway, I'm not so sure – but I'm meeting up with them anyway. This whole dual diagnosis service is super because it makes perfect sense to me that everything must be treated together. My social problems, my mental health problems, my addiction problems – they're all part of me and why should I be going to different places around the city or different services to meet with people when I can do it with one team and one service here all at one – I think its super. I don't know how they could make it better really. Tis fantastic'.

On a day to day basis, Mary describes how the dual diagnosis service enables her to engage with others in various aspects of the service, reducing feelings of isolation that enable her to speak while she also hear others who share similar experiences.

'Well the groups are fantastic, I dunno how I'd manage without it now to be honest. It really really helps me to meet with and talk with other people who are the same as me, I'm not alone anymore I spose really like…. alright the addiction or mental health problems might me different but we're all similar kinda….we all share common problems like…I have to say hearing people and their stories helps me…..makes me

realise there is hope for me. They've been there too and they've managed ya know….The support I get from..... really helps. He doesn't give out saying you shouldn't be drinking, he'll ask okay you drank, so what's your next step, no hassle like you know….He sees it as in the past and that I need to move on. That's great cos there's no criticism just accept what's happened and move on….I also find the one to one work and nursing support too helps. It gives me a space to discuss what's going on for me and that helps cos I sometimes realise that things aren't actually that bad, sometimes all I want to do is talk…sometimes…'

Service integration was further demonstrated by Mary's experience of one systemic approach:

'Was there a service then? I'm joking. Yeah the service then was nothing like the service now. Back then each thing was seen as separate and the group was the only crossover. I had to attend two services, mental health and addiction, you know I got tired of repeating the same thing over and over. Perhaps if someone had said I dunno she attended clinic today and she said... and this was documented in the other service, then they would have been up to speed to where I was at then and maybe my care would have improved, back then the only crossover was the dual diagnosis group and there needed to be more.'

While describing her experience of the new service, Mary described how the current service could be improved considering her overall needs.

'To be honest the current services are brilliant. Because there's at least one person who makes sure my care is managed I find that I don't have to repeat myself when I go to the different services….because of this I feel my care is overall like a lot more taken care of do ya know what I mean…..I recently finished a course, like a back to education kind of thing and this has helped me no end like…)pause)….t'was great to be mixing with other people in St. John's cause I felt kinda normal to be in school like…I also had access to things like acupuncture. That's so so good for relaxing and destressing me, J…. had an acupuncturist come in to the group a few times and it was amazing, I go to Arbour house too for the acupuncture a few times a week. The one thing I think is needed is a person trained in mental health and addiction available to talk with someone like me. Now don't get me wrong the services are great but cos each condition is still kinda looked at separately it's hard to look at me as a whole person,

you know what I mean, yeah grand mental health is mental health and addiction is addiction but for me there both one, so I think if you had someone who knows how to deal with both at the one time it would make a lot of difference… that's my opinion anyway.'

Mary continues to access elements of the overall dual diagnosis service in accordance to her complex needs. She maintains regular employment in a part-time capacity, and dedicates much time to her familial relationships in psychotherapeutic, educational and social capacities. She takes a harm-reduction approach to her ongoing prescription drug use, which is collectively supported by her GP and dual diagnosis services.

Case study: Two

Testimonial excerpts were selected from the participant's case notes and from interview. The name Jim is fictional and was selected for narrative purposes. The abbreviation ***p.19*** was used to identify this participant in transcribing the recorded interview.

Participant details, documented interactions with mental health services prior to engagement with the dual diagnosis service:

'Jim is a 41 year old single male, who lives alone. Well known to mental health services. Previously diagnosed with Schizophrenia F20.0. History of substance misuse which has led to admissions to the inpatient services South Lee Mental Health Unit. Can experience auditory and visual hallucinations when unwell, but currently denies this. Presently experiencing a deterioration in mood with poor self-care and poor dietary intake. Reports being tearful and crying at times. Staying at home, no interest in going out or in watching television. Community Mental Health Nurse has been calling daily to Jim due to deterioration in mental state. Receives daily telephone support also from Nurse Therapist. Has weekly outpatient appointments to monitor mental state. Possibility of non-concordance with medication contributing to deterioration. Clozapine nurse reports 3 weeks supply of clozapine has been returned to pharmacy as it was not collected by Jim.'

Case history, selected from case notes: (PRE INQUIRY)

Psychiatric:

> *'Well known to mental health services. Has had previous admissions, usually in the context of psychosis due to substance misuse. Can experience visual hallucinations of a religious nature and auditory hallucinations. History of using cannabis and head shop drugs. Other issues include alcohol and gambling.'*

Current Mental State:

> *'Jim is tearful and crying at times. Reporting he is self-isolating, staying in bed and not interested in anything. He admits to poor sleep, waking in the middle of the night and finding it difficult to go back to sleep. Denies experiencing auditory or visual hallucinations. He reports having `poor energy' and he's `not great'. He states that he had 'a few cans of Heineken' a few nights ago (7-8 cans), and smoking ' 1 joint of cannabis' recently. He reports he is not eating or attending to his hygiene needs.'*

Collateral History:

> *'Jim's sister who sees him daily reports that Jim `is not himself, that he has been `worsening recently 'and that he admitted to her that while he was taking his medication he had recently `smoked one joint of cannabis. She reports that she is now really concerned about him, as he has no interest in going out or in eating.'*

In 2016 (in Cycle Three of the inquiry) Jim was referred by his community mental health nurse directly to the dual diagnosis service.

Theme 1. Experiencing the referral process

The initial theme emergent from the data analysis demonstrated Jim's experience of the referral protocol, whereby his community mental health nurse directly referred him to the new service. However, as the same nurse is a member of a mental health team participating in the inquiry and has visited Jim's home frequently over many years, it was unclear why she had not referred him to the service before 2016. In a similar systemic context to that of Case Study One, this service-user's experience of the referral process in this Cycle demonstrates that practice transformation has occurred in the context of the referral process.

Jim's referral to the service demonstrated that the community mental health nurse employed the referral protocol. However, the same nurse is part of the mental health team participating in the inquiry and has visited Jim's home frequently over many years. It was unclear why she had not referred him to the service before 2016.

The nurse highlighted Jim's recent cocaine and alcohol use and his ongoing gambling, stating:

> '*Jim drinks a couple of nights a week, the drug use changes seemingly to what's around the place, though as he goes gambling at the end of the night when he's out, it all impacts on his income and it seems to be the same merry-go-round with Jim*.'

Upon referral, Jim began to attend many aspects of the dual diagnosis service in 2016, including group and individual psychotherapy, mindfulness and relaxation classes. Agreeing to participate in interview, Jim described his experience of mental health services prior to his referral to the new service:

> '*My doctor referred me to GF* (acute inpatient mental health service unit) *and I was admitted…after that…that was it I spose I was out but I didn't know about other stuff then ya know what I mean…there wasn't much talk about stuff really I spose….'*

In reference to services that were made available outside of the inquiry context regarding his co-occurring mental health and substance use concerns, Jim stated that:

> '*… I was inside hospital for a few months and when I got stable I was discharged (pause)…and at the time the services that were available to me... (pause)….there wasn't much I suppose other than AA and NA and the nurse in the community would call around sometimes but not much ya know…'*

Prior to Jim being made aware of the dual diagnosis service, he describes the referral options at the point of hospital discharge back into the community that were available to him:

> '*after hospital like you know where you go and talk to a doctor, any doctor for five minutes….you could be waiting two hours and then you were in and out in five minutes. I was told to go to the addiction services to look at the amount of alcohol I was drinking, I really don't think they knew it was how I coped with my feelings, you know, the feelings of worthlessness and that drink helped me relax and chill after a stressful day with the sister's kids around….so I suppose for me the services available were,*

GP, outpatient appointments and the addiction services. Out-patient clinic to monitor my mental state and the addiction services for my drinking….it was, over in St. Finbarr's Hospital and when I went there because I had a diagnosis of schizophrenia they told me that to go to AA because I was drinking and because I was using drugs to go to NA that – that's where I was told that I could go, either to the AA or NA and to go to Arbour House for treatment but I didn't get any follow up appointment there and I didn't want to go with it anyway. I got a referral letter then for my next outpatient appointment with the psychiatrist.'

In contrast to previous experiences of the organisation's mental health services, Jim describes his most recent hospital experience where he was referred to the new dual diagnosis service:

'*Oh tis a different ball game altogether this time because, am, when I was in hospital or when I was discharged from hospital this time I had met somebody from the dual diagnosis team. I met two people actually. I met J… and I met F…. and the two of them were working with the dual diagnosis team both in the hospital and outside in the community so I knew who I was going meeting when I went home and part of the care plan that I was given told me where I was going, who I was meeting and what I'd be doing and I'd been talking to ….about that anyway about group work and individual work all of that kinda stuff to do with my addiction and mental health. I didn't know anything about that kinda stuff before not really anyway but I was given much more information this time ya…'*

Theme 2: Experiencing service integration

Jim further described both hospital and community dual diagnosis services and in particular how the integration of services are of benefit to him:

'*There's a lot more groups….my God the building is fabulous, but there were a lot more groups, there's relaxation, there was art therapy…they were going on before as well but I didn't have much to do with them and I don't know why. I don't think I could've gone up to Arbour House before without they asking a hundred questions at the reception, tis grand I can go in now no hassle…'*

In relation to the interplay between his mental health diagnosis and his substance use, Jim described a shift in service provision in this regard:

'the big thing I spose for me with the drugs, with my addiction and relationship with alcohol and drugs that affects my mental health was the fact that (am) there was a lot more information given to me about it this time and much more talk about it too…..more talk about my mental health problem, the schizophrenia and the psychosis and stuff…This time it's a totally different ball game….I learned an awful lot more about my condition from being in hospital this time and there was a big link between my mental health and addiction and the talks around it this time than before. Dunno that's how the treatment differed. As well as that the people that I'm now working in the community with, and …, and the team there in the community that actually started when I was in the hospital this time. They came in from the community into the mental health unit and we started working together, I got to know them, others in there as well in a similar kinda of situation as myself, we were working around it, what do they call it, psycho education or something – twas stuff around that really that made me realise what I was doing and the effects that the alcohol was having on my mental health and the cannabis that I was using that that was having on my mental health and of course I had stopped taking medication then when I'd be drinking and using cannabis and I get sick – I'd get very unwell then. I learnt a lot more about that this time…before I didn't get any of that really, it wasn't there or any people like that but maybe things have changed I don't know.'

Jim describes how engaging with varied aspects of the new service enables him to engage with others, reducing his long-standing experience of isolation in practical ways:

'Ya, everything is spot on now….All the services that are available to me and all the gang I spose – I can go to acupuncture – I'm going ... (pause)...three times a week. I could go 4 times if I wanted but I can only make it 3 times in the week. I go to the dual diagnosis group on a Thursday morning. I meet up with …. Then for anxiety and stuff. I meet up with … then as well around addiction issues and stuff and how all that affects my mental health. I go to NA a bit, maybe I should go a bit more than what I'm going to them but I'm doing fine really now and I still go to my psychiatrist (pause) when I should. So I'm getting to know all of ye and the other people too. I meet with (pause)....the occupational therapist. The social worker that's on the team meets up with me – so I have loads of people on the team that I go to… I'm going to see them

more often now and tis good for me to get out ya know….regularly and tis... I couldn't fault it really – it's spot on...tis super ya. '

While describing his experience of the service, Jim described how the current service could be improved:

'*I don't know how it could be improved now. I suppose one thing I do find it difficult sometimes is to get out of the house on my own. I have a tendency to isolate. I've always done it. I'm living on my own. I do feel uncomfortable, sometimes, or afraid to go out, sometimes, of the house. I'm always better when I do but it is hard to get out sometimes. I don't know how the services could help me with that. I am getting out at the moment but come the winter – look at me in the winter time back over the years and I find it hard to get out and I must plan around that now. If the services could help me with that kinda of stuff, but I don't know how they could do that now. No, only everything is going fine now I must say. This service seems fantastic…. I just hope I keep going now, because I don't want to go back to the way it was before like.'*

Jim is aware of the dual diagnosis services that are now available to him. His ongoing/intermittent drug and alcohol use is monitored by his GP, and practitioners from the overall dual diagnosis service. He maintains regular contact with his sister, enjoys a dynamic sporting/social life and has recently returned to education.

Data analysis discussion

This section refers to the integrated analysis and findings emergent from the collective data and interactions between participants over this Cycle of inquiry. Excerpts from participant observations, journaling, field notes and case studies are reflected within the cyclical processes from which they emerged. The core research group planned the case study approach, designed the interview questions, and consistent with previous Cycles likewise conducted the collective data analysis for the Cycle. The emergent themes: *One: experiencing the referral process*, and *Two: experiencing service integration*, are discussed individually below and within each study as each relates to plans for Cycle Three and to the overall inquiry.

Considering the case studies and the context of the Cycle within the overall aims of the inquiry/service development, core research group participants agreed that it was important to plan to capture the unique perspectives of these service-users. The objective of which was to illustrate their subjective experience of the transforming service. Both participants engaged

with the dual diagnosis service in this Cycle of inquiry. They both accessed the service via the service's referral protocol, which demonstrated that the referral protocol had been embedded, as far as those two referrers were concerned. However, while other referrals into the service likewise demonstrated that the referral protocol was embedded, there were other potential referrers in the organisation and in the wider social system that were either not aware of the referral protocol and/or did not utilise it. For example, field notes taken by a core research group member noted: '*talking with …….'s GP last week, he had no idea that he or his colleagues could refer into the service and in fact he knew very little about the service itself'*. This suggests that the referral protocol was only partially embedded, where some GP practices had received the referral protocol and others had not. This may have been indicative of how long it can take for such newly introduced work practices to become fully embedded across large geographical/sectoral areas like these. In this, more time was required for core research group members to continue disseminating pertinent information about the overall service and in particular the referral protocol to relevant services/practitioners across the broader social system.

Both case study participants demonstrated availability and access to dual diagnosis services that were either previously unavailable to them or that they had not been made aware of. While participants stated benefits from having accessed such, data from case notes and interviews collectively demonstrated that referring into the service was not as efficient as it could have been. For example in Mary's case, while she did not attend mental health services from 2012 to 2015, she did regularly attend her GP who for some reason did not refer her to the dual diagnosis service over those years. At the time of interview, if he had offered/suggested the referral to Mary at that time, she did not mention it.

From Jim's interview and review of his case notes, it is even more concerning why he had not been referred to the dual diagnosis service before his hospitalisation in 2016. The community mental health nurse who called to his home almost every week from 2011 to 2016 was a member of one of the teams participating in the inquiry. Why she did not make the referral may be related to resistance on either her part or on Jim's, though future discussion/reflections with hopefully answer this. However, for the ongoing development of the service, it is important to explore why individuals (like Mary and Jim) were not referred sooner to the service that on paper (the service's referral protocol) was easy to refer into and to access.

While ongoing service development work is required to make the referral/access to the service more broadly known and/or more efficient, both case studies have collectively illustrated that dual diagnosis service transformation had indeed taken place.

The first theme that emerged from the data analysis in this Cycle was '*experiencing the referral process*'. The referral process had also emerged in previous Cycles, where plans for Cycle One for example included *the development of a referral pathway* (p.133), an action which did not take place until Cycle Two. Emerging from the data analysis in Cycle Two, as a theme i.e. '*identified need for a structured referral pathway*', the referral protocol was developed later in that Cycle in conjunction with the development of the service's operational policy. Though findings demonstrated that while the protocol had been distributed to many potential referrers, it was not fully embedded across the organisation and/or the participating sectoral areas as planned for at that time. There may have been many reasons for that, though considerable time was absorbed developing the service's operational policy, which upon reflection inadvertently avoided the practical tasks of completely embedding the referral protocol. Where participants expressed the referral process/protocol as a service necessity in previous Cycles, the emergent theme in this Cycle's analysis reflecting participants' collective experience of such. In this, participants' experience of the referral process has met two of the overall inquiry objectives: (a) *To engage stakeholders in PAR's methodological framework to facilitate a clear pathway to services*, and (c) *To enact pragmatic developments in service delivery that demonstrates positive outcomes for clients experiencing dual diagnosis* (p.8).

The second theme, *experiencing service integration*, signified participants' experience of accessing the integrated dual diagnosis service in this Cycle. As service integration was an integral element of the overall inquiry aim (p.8), plans for Cycle One had collectively incorporated service integration as its overall focus, with the interim coordinator role instrumental in bringing that about in practice (p.151). Much of the embedding of services that occurred in Cycle Two inherently included embedding that service integration that had started in Cycle One. This continued into Cycle Three where case study participants demonstrated their experience of the integration of these aspects of the dual diagnosis service, many of which, as discussed, were previously fragmented and/or functioned independently of one another (pp.8-13). However, the experience of service integration was widely reflected throughout this Cycle where participants from MDT's, primary care and mental health teams

integrated with one another, and with service-users in the final process of embedding the new dual diagnosis service into routine practice. Figure 16 (p.220) further symbolises this integration, where participants functioning at various levels of the organisation collaborated in embedding this new service.

Evaluation

The inquiry process dictated that Cycle Three had started earlier than previously expected. What that meant in practice was that plans and actions for Cycle Three were taking place while the *ends in view* for Cycle Two were still evolving. While the *ends in view* for Cycle Two included elements of what a contemporary dual diagnosis service appeared to include, those perspectives were further modified through achieving the plans for this Cycle. In this regard, the evaluation includes an exploration of the findings on the overall inquiry up to May 2017, though focusing initially on plans and findings from Cycle Three. As agreed by core research group participants, I recognise that the collective evaluation is my interpretation of the participants' involvement in the inquiry process and the *ends in view* as of May 2017. The Critical Discussion chapter below extends this evaluation, whereby an analysis of the inquiry's findings concerning implications for practice is presented.

Co-occurring systemic and social influences

Additional local responses to dual diagnosis

Figure 17 below illustrates some organisational and social changes locally that co-occurred with this Cycle of the inquiry. While these did not directly emerge within the inquiry context, some influences may have occurred arising from interactions between participants and within the overall realm of integrating services as part of this inquiry process.

The increased local response to dual diagnosis by specialist addiction services (outside the inquiry context), started at the time Cycle Two was merging into Cycle Three. As these programmes were emerging, I was invited to meet with the coordinators of that service with a view to integrating the management of care for service-users accessing our collective services. The participants in the inquiry, including myself, commenced collaboration with personnel in those services in the context of inter-referring service-users, or where inquiry participants supported service-users in the assessment process for one of those DBT programmes. While not directly impacting on the inquiry process in itself, this inquiry may have influenced the emergence and delivery of those new programmes. It is reasonable to

suggest likewise that inquiry participants have been influenced by the emergence of those programmes. In effect, because of the collective process of integrating services, including those specifically designed (with varying philosophical, methodological approaches) for those experiencing dual diagnosis, both service-users and service providers can only benefit from such integration.

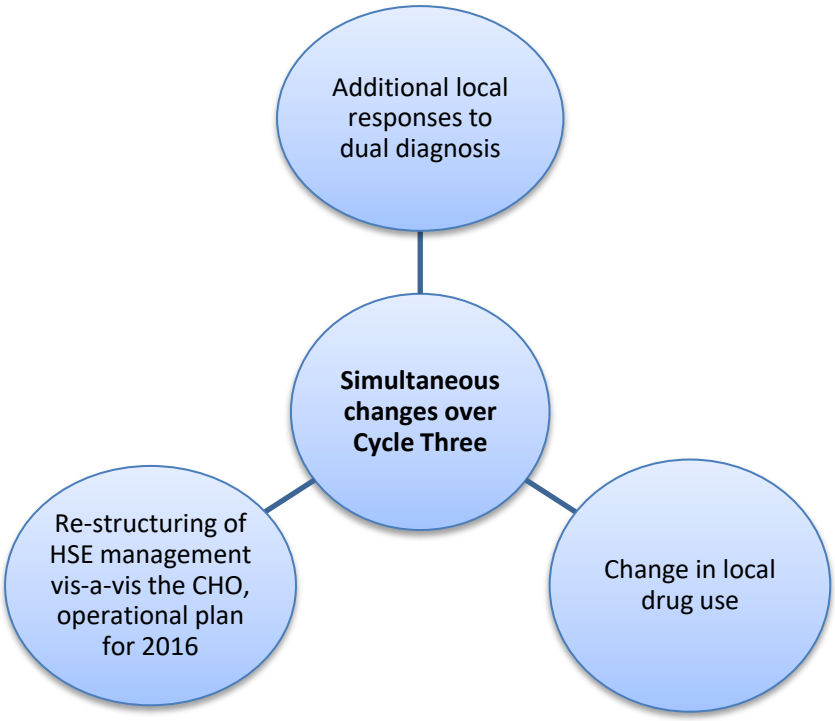

Figure 17. Concurrent systemic and social influences in Cycle Three

Changes in local drug use

It was difficult to determine if the drug trend began to change prior to Cycle Three, but it became evident that it had begun to change during it. The marked change was not in the drug type per se, but in the escalation of the use of cannabis, particularly within the 20-28 year-old male cohort. The change was the increased prevalence of cannabis-induced psychosis presenting to the acute unit over Cycle Three, which increased our collective response in both hospital and community dual diagnosis services. For example, in the Togher/Ballyphehane sector for the twelve-month period within Cycle One, 9 males and no female presented to the acute unit with features of cannabis-induced psychosis, whereas from October 2015 to

September 2016 (co-occurring within Cycle Three), there were 28 male and 2 female hospital presentations with cannabis induced psychosis.

The re-structuring of the HSE's sectors and within this the management teams involved in this, became apparent in the regions *Cork and Kerry Operational Plan 2016* document published and coinciding with the approximate timeframe of Cycle Three. While that re-structuring process may have influenced changing personnel roles in the local management team with whom inquiry participants were communicating, it was difficult to decipher if responses to the documentary submissions made to management were affected by changes within that management team at this time.

Service change and participation

Participant observations discussed within the core research group indicated that, following previous Cycles, changes had equally taken place in this Cycle. Observations differed, however, as some participants were familiar with the organisation prior to the inquiry, while others had more recently joined or accessed the organisation. Such diverse perspectives created some ambiguity in terms of developing mutually agreed understandings within the core research group and with other stakeholders. Despite this, participants agreed that *the appeal of collaboration* percept remained visible and relevant to ongoing participation and change in this Cycle. Where *the organisation's readiness for change* percept had emerged as a question in Cycle Two, it was equally relevant in this Cycle, though it was modified from being a question about *the organisation's readiness for change* to the organisation actually participating in change. The pragmatic approach was brought about by the development of participatory relationships through dialogue, evidence of which are illustrated in this Cycles findings (Gustavsen, 2001; Raelin, 2012).

While participation in this Cycle (and indeed in the overall inquiry) was an evolutionary process, the collective learning experience of participation seemed to be realised through participants' flexibility in this Cycle. This was in contrast to the *resistance* of participation that had permeated previous Cycles, though what did seem to continue was how newly recruited personnel differed from those who had been employed in the organisation for many years. Participants had, of course, engaged with those willing to participate and with those who were not in previous Cycles, while overall observations in this Cycle certainly demonstrated both a transparency and a greater flexibility from those wanting to participate,

albeit with varying degrees. With participation being a central tenet of the methodology, what that has meant for the overall inquiry warrants further discussion, which is included in the Critical Discussion chapter below.

Working with power dynamics

Findings from Cycle Two demonstrated that power differentials permeated that Cycle in various ways. One example was the application for additional resources to management and the ensuing frustrations of core research group participants when the application was not responded to. Among other examples already discussed in Cycle Two, the non-response to that application may have symbolised resistance from those in greater positions of power in the organisation. As a percept that emerged in Cycle Two, *the appeal of collaboration* remained in this Cycle. This was evident as engagement levels increased on one hand, while paradoxically disengagement and/or resistance to participation seemed to depend on subjective interpretations of what was appealing or not about collaborating in the service development process.

For example, during the identification and formation of that percept in Cycle Two, core research group participants largely agreed that resistance was located within the organisation's management structure, none of whom we had actually met at that time. Upon reflection, even though the resources application was not responded to, for the core research group to situate resistance solely within the organisation's management structure may have been either naïve or misplaced. Participant observations suggest that resistance was also present within the core research group itself, consequences of which may have prohibited earlier engagement with management on many issues. For example, core research group resistance was evident in the length of time taken to develop the service's operational policy document. Because of this, implementing the referral protocol (which was planned for Cycle Two) in practice was delayed until Cycle Three. Resistance by the core research group was demonstrated further by their lack of communication with the organisation's management team (apart from the additional resources application) for twelve months prior to their agreement to participate in finalising details of the operational policy.

However, as Cycle Two merged into Cycle Three and as participants appeared to be more transparent and flexible in their collective approach to participation, communication through the hierarchical structure of the organisation seemed to be more fluid. What seemed to have

taken place was that the percept was further refined. From acknowledging where the resistance was located, it was explored through dialogue, which then positively impacted on collective engagement/participation. From working with resistance, dynamics of power differentials were equalised, enabling the collective process to move forward. As Newton (2009) states:

> '*Resistance is not simply a force to overcome, it indicates a different viewpoint that should be listened to and explored*' (p.257).

Achieving Cycle Three plans

The inquiry methods adopted in this Cycle enabled participants' experience of the dual diagnosis service to be illustrated and explored. As in previous Cycles, the evolutionary change in practices was explored by the core research group, while this Cycle provided further evidence of service transformation through the unique perspectives provided by participants' case studies and by other participant observations and field notes taken throughout the Cycle. Achieving the Cycle's plans were demonstrated in the findings where participants described verbatim their experience of the new service and where service development was experienced as an ongoing process. In this, evolving *ends in view* were further refined as participation increased and as the service entered a process of formalisation within the organisation's management structure.

As one element of the Cycle's plans, achieving engagement with the organisation's management undoubtedly stemmed from the core research group's ongoing critical reflection processes. An example of this was evident in the communication process concerned with sustainably implementing the service operational policy in practice. In this, management were processing the service's operational policy document, whilst simultaneously participating with core research group participants in planning further action changes contributing to the service's sustainability. A communication process between management and an inquiry group in practice may be somewhat uncharacteristic within a hierarchically structured organisation where policy usually filters down the political tiers. Considering this, the process of achieving plans for this Cycle appeared to benefit from the ongoing process of critical reflection. Within this, and while taking considerable time to evolve, participants appeared to learn to critically look at themselves, and at others in a non-judgemental manner. This renewed openness amongst participants seemed to facilitate flexibility in the general interactions between

participants both within the inquiry groups and in less formal settings across the organisation and community.

There was sufficient exploration of findings from within Cycle Three to indicate that the Cycle's plans to *(a) implement the service operational policy into practice* and *(b)* to *explore the experiences of the new service from the perspective of service-users within two case studies* had been achieved. The broader exploration of the inquiry process will help evaluate further to what degree this Cycle and the overall inquiry objectives have been achieved.

Reviewing overall inquiry aims

The success of the overall inquiry depends on achieving the inquiry's aim and objectives through PAR, the chosen methodological framework. The over-arching aim was to develop an integrated and recovery-oriented dual diagnosis service within the environment of primary and continuing care in Cork. The four objectives are listed and discussed below, the achievement of which would demonstrate that the aim was met. To illustrate how the inquiry process set about achieving these objectives, I outline here how the aim was met and how effective the findings of the inquiry were. Figure 19 (p.263) below represents the correlation between percepts, organisational dynamics and service developments that emerged over the inquiry process.

1. *To engage stakeholders in PAR's methodological framework to facilitate a clear pathway to services.*

Engaging stakeholders began with relative ease in Cycle One, where it formed a percept which became a focal point in Cycle Two and was further refined in Cycle Three. The participative process of keeping focus on and refining this percept through all three Cycles enabled the inquiry to evolve within a fluctuating though engaged stakeholder structure. In this, Lewin's (1946) cyclical framework of *reflection, planning, action and observation* was re-defined and was the methodological structure that facilitated stakeholder engagement. The evidence has been the co-construction of both new services and access to other services that were previously inaccessible for service-users. The development of the referral protocol and the operational policy took longer than expected. When the documentation was ready for dissemination, the clear pathway to services was evident both in policy and in practice.

2. *To engage stakeholders in a critical reflective process seeking to collectively understand existing and emerging concepts and beliefs relative to the topic of inquiry.*

The core research group was formed in Cycle One, where critical reflection in the context of dual diagnosis service development became part of regular stakeholder meetings. Critical reflections within this forum initially included the exploration of additional services, including psychotherapy groups, access to acupuncture, mindfulness and individual therapy. In Cycle Two, when the referral protocol and the service's operational policy were under development, the benefits of critical reflection became apparent within the core research group and across the organisation. Within this, the meanings that derived from critical reflections formed new percepts that helped stakeholders understand the ways in which the process was unfolding. Stakeholders were challenged as they represented diverse perspectives concerned with the development of a dual diagnosis service. Apart from a number of months in Cycle Two, stakeholders remained engaged in critical reflection throughout the inquiry. This was mostly evident within the core research group forum, though inevitably it emerged with those who had become familiar with critical debate in other practice settings.

3. *To enact pragmatic developments in service delivery that demonstrates positive outcomes for those experiencing dual diagnosis.*

From the outset in Cycle One, new services were developed and delivered. The unique aspect of such developments was the active participation of service-users in all phases. In Cycle One, these developments were in direct response to participants' needs, and what was practically possible hinged on what organisational resources were available at that time. While *ends in view* represented the change that was taking place, findings from Cycles One and Two demonstrated positive outcomes from service-users in terms of established services. Findings from Cycle Three further illuminated benefits service-users were gaining from the new service, in stark contrast to what the organisation had to offer before the beginning of the inquiry. These unique perspectives were provided by participants experiencing dual diagnosis, who had accessed mental health services in 2011, before the inquiry started, and who had re-engaged with services again in 2016. The evidence provided by these participants demonstrated how they were benefiting positively from the dual diagnosis service that had developed. This included meeting with dual diagnosis service personnel at the hospital/acute phase of their engagement. This initial engagement continued into community interventions and supports upon discharge. Participants stated that with this engagement with services, they were more informed about what they were experiencing (dual diagnosis), and were directly integrated with a suite of support services unavailable to them in 2011.

4. *To contribute to learning, knowledge development and new ways of knowing for stakeholders concerned with dual diagnosis.*

PAR has facilitated participants' engagement with the collective generation of knowledge and service development. A practical theory has emerged from this process, which is continually evolving. New ways of knowing about the development of a dual diagnosis service have informed the varying formations of theoretical development, and were presented at the end of Cycles One and Two. This co-construction of knowledge may contribute to the literature on dual diagnosis development in organisational contexts. As the literature suggests, varied methodological approaches adopted in the research of dual diagnosis have been largely influenced by those working in the institutions of psychiatry, psychology, mental health and addiction services. Further, the dominant approaches to dual diagnosis research have been '*on*' or '*about*' those experiencing dual diagnosis, inherently creating a distinct distance between the researcher and the researched. Conversely, the approach and findings from this inquiry contribute to the perspectives of participation and research '*with*' people experiencing dual diagnosis. This contribution is discussed further in the Critical Discussion chapter.

The inquiry has highlighted possibilities for improving the response to dual diagnosis within mental health and primary care services. However, particular elements are relevant to this inquiry only. The over-arching aim of the inquiry was to develop a new dual diagnosis service in an area where it was not previously available. While the aim of developing a new dual diagnosis service has been achieved, the development of a practical theory within this inquiry context indicates that inherent components of such do not transfer to other contexts. However, where other primary care and mental health services may decide to integrate, understandings derived from this context may inform initial theoretical insights.

Conclusion

Considering the breadth of policy documents on dual diagnosis, no effective treatment response was found. However, the application of PAR in this particular context has enabled the development of this dual diagnosis service to take place. This came about through the collaboration of multiple stakeholders, where service-users experiencing dual diagnosis actively participated in the service development with employees. Through regular critical discussion and the generation of participant data, emergent findings have illustrated multiple

benefits for participants. This was a very positive outcome in itself, and the findings show that it has continued to influence the ongoing development of the new service.

In my initial research proposal, I proposed that service-users experiencing dual diagnosis ought to have access to a wide range of services in their own community without any systemic or restrictive barriers. I further proposed that applying PAR's methodological framework could bring this about. Even though challenges were encountered along the way, and the process continues to evolve, the situation is indeed positive.

Perceptual framework and theoretical development

T*he appeal of collaboration* percept permeated the inquiry in that the engagement of stakeholders was critical. For example, Cycle Two's *ends in view* identified the participants' resistance in aspects of service development and operational policy implementation. From this, core research group discussions concerning *the appeal of collaboration* percept led to questions concerning *the organisation's readiness for change,* which then emerged as a percept in itself. Core research group participants agreed that while there were strong correlations between these two percepts, they remained relevant individually as Cycle Three evolved into Cycle Four. For example, plans in Cycle Three included service expansion in the hospital simultaneously with my withdrawal from the process. The engagement of stakeholders was critical to this and other continuing service developments. While encompassing this overall transformational process, the percept in Cycle Two, where *the organisation's readiness for change* was being explored in many respects, not least its apparent resistance to engagement/participation, was further refined in this Cycle. In particular, as the service's operational policy and new service expansion were being implemented in the latter part of Cycle Three, the evolving *ends in view* were that the organisation had demonstrated both readiness for, and participation in, change. Evidence of the organisation's readiness for change was demonstrated in many elements of Cycle Three, though most critically where management engaged in both finalising the operational policy document and by supporting its implementation.

As service developments continued to be embedded and new additions planned for while implementing the operational policy, the impact on practice was probably more visible in this Cycle than in Cycle Two. The evaluation in this sense would suggest that the wider organisation was benefiting from outcomes that evolved from the inquiry overall, rather than

from any one Cycle of inquiry. Ultimately, a new dual diagnosis service has been developed, with further developments and increased levels of stakeholder participation taking place, and the impact from this will most likely be seen in Cycle Four. In this, the *ends in view* from Cycle Two evolved into the experience of what a more developed dual diagnosis service ought to be like in Cycle Three, the unique experience of which participants had vividly described. The perceptual framework at this stage includes *ends in view* which demonstrate a working dual diagnosis service, where participants have provided clinical outcomes and a specific service operational policy has been developed. All of these elements of the service are moving forward as the process spirals into the next Cycle with further exploration of amalgamating percepts required. The practical theory developed in Cycle Two (p.214) is still relevant, while this Cycle has progressed the theory further, verifying that the indeterminate *situation in view* became determinate, as illustrated in Figure 18 below.

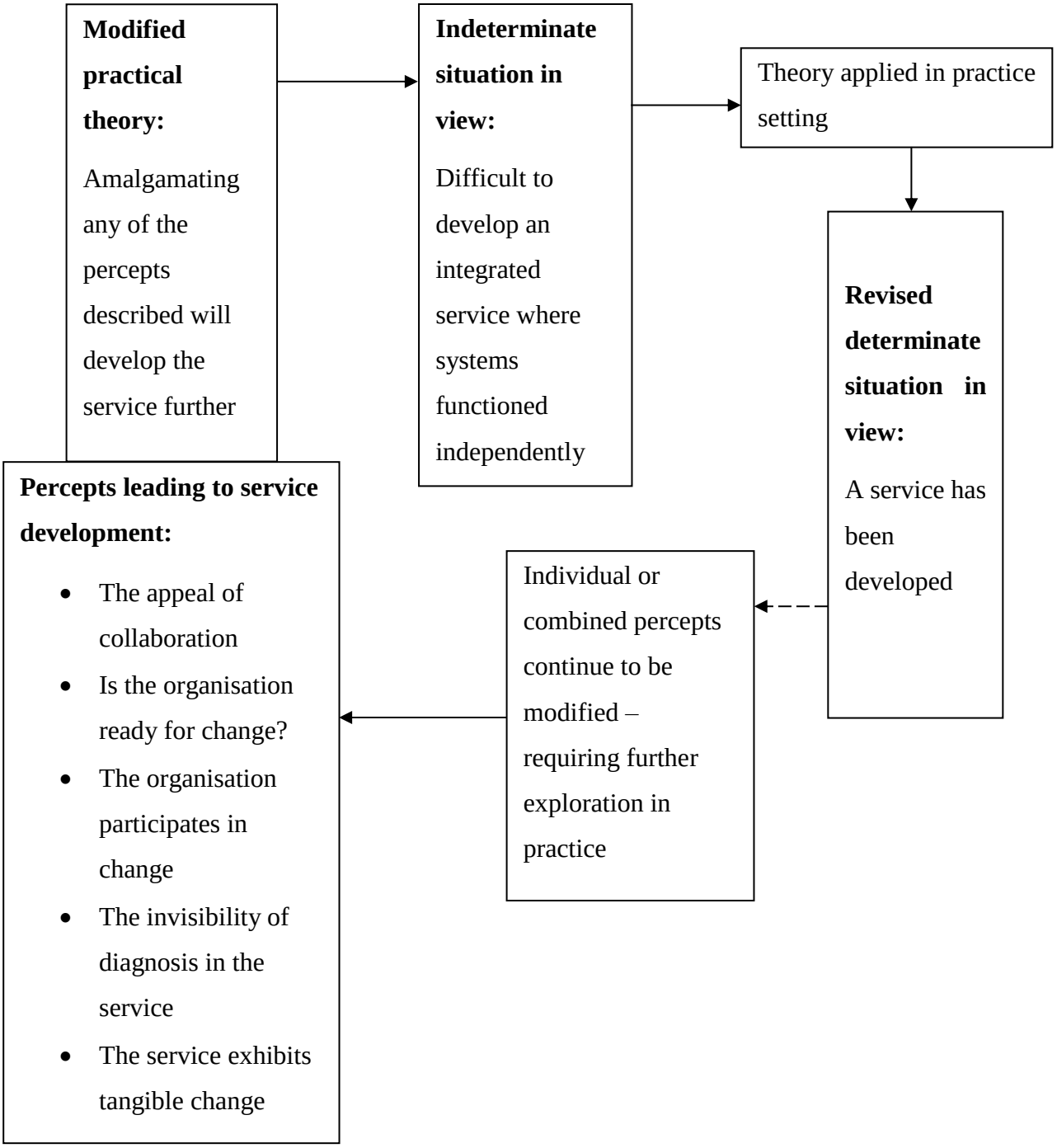

Figure 18. Illustration of practical theory evolving in Cycle Three

CHAPTER EIGHT: CRITICAL DISCUSSION AND IMPLICATIONS FOR PRACTICE

I believe this dissertation presents an accurate account of the participatory action research (PAR) approach to the inquiry/service development concerned. Cycle Three comprises illustrative discussion and evaluation of the situation in view at the time, all of which evolved over previous Cycles within the philosophical worldviews of PAR and pragmatism. Some aspects of the inquiry are worthy of further discussion, as these may have implications for further research relevant to service development for dual diagnosis. Reflecting on these, I discuss potential implications for practice within the inquiry context, and likewise for the potential development of dual diagnosis services generally. Furthermore, the inquiry contributes to knowledge concerning the application of PAR in a public-organisational context and how this relates to the evolving practice environment of primary health care delivery in Ireland. Such knowledge outcomes are discussed here as they relate to the sections below.

Firstly, the inquiry's aim and objectives are re-presented, followed by an overview of what was found over the inquiry process.

- The overall aim of the inquiry was to develop a comprehensive, integrated and contemporary recovery-oriented model of care for dual diagnosis within the environment of primary and continuing care in Cork, Ireland.

This aim was met through applying the following objectives:

- The engagement of stakeholders in PAR's methodological framework in order to facilitate a clear pathway to services.
- The engagement of stakeholders in a critical reflective process seeking to collectively understand existing and emerging concepts and beliefs relative to the topic of inquiry (dual diagnosis and related service transformations).
- The enactment of pragmatic developments in service delivery (through PAR) that demonstrates positive outcomes for service-users (stakeholders) and families experiencing dual diagnosis.

- The contribution to learning, knowledge development and new ways of knowing for stakeholders concerned with dual diagnosis.

Overview of findings

- A dual diagnosis coordinator role was implemented, which was found to be fundamental to facilitating access to and development of specific dual diagnosis services.
- Stakeholders formally applied to the organisation (HSE) for additional resources, including service-specific posts, with the objective of ensuring sustainability of the service.
- Stakeholders developed a dual diagnosis referral protocol, which is implemented across participating HSE sectoral areas in Cork city and county.
- Stakeholders developed the *Dual Diagnosis Service Operational Policy*, which was approved by local HSE management and is awaiting final formalisation.
- PAR has demonstrated efficacy as a transformational agent through a new way of doing, evident in the design, development and implementation of a dual diagnosis service. Emergent from the perceptual framework and the inter-relational dynamical process, this contribution to knowledge constitutes a new way of knowing concerning service development.

From these findings, the following inquiry elements warrant further discussion:

A theoretical and practical contribution to knowledge

This was a practical inquiry that set out to develop an evolving practical theory that would build on understandings concerning services for dual diagnosis. Findings from the inquiry demonstrate that the aim and objectives were met, whereby participants engaged in a collaborative process that led to their being able to access a range of services which were previously unavailable or inaccessible. The percepts that emerged over the course of the inquiry helped shape the service development, with the inherent participatory process also contributing to theoretical knowledge in this domain. A review of the percepts here provides context, while Figure 19 below illustrates the evolution of the practical theory as the service developed.

Organisational members buy-in

This initial percept emerged as stakeholders began to engage or *buy-in* to the participatory process of service development. Whilst resistance to participation was also present, members of the organisation (staff) who may have been initially reluctant to get actively involved in the process, were now engaging in more meaningful and sustainable ways as Cycle One progressed. This was evident both within core research group activities and also in the active implementation of the service developments that occurred at this time.

The appeal of collaboration

This was where participants realised that participation in the inquiry was dependent on each individual's subjective commitment to the participatory process. In this, stakeholders appeared to '*buy-in*' to elements of the collaborative process, based on whether those aspects of the inquiry/service development were subjectively appealing or not (Thundiyil et al. 2015; Rafferty and Jimmieson, 2017). If the motivation behind stakeholder engagement is subjectively experienced, and if this can be either consciously or unconsciously realised, engagement may inevitably fluctuate. From this, the appeal of collaboration remained an independent percept throughout the inquiry, though its presence merged with other percepts as represented in Figure 19 below. The knowledge gained from the influence that this percept had on organisational dynamics throughout this inquiry, particularly in terms of assessing and working with organisational readiness for change, may have implications for practice development in this regard (Shea et al. 2014).

Is the organisation ready for change?

The emergence of this percept in Cycle Two was based on evidence of resistance demonstrated by the organisation which simultaneously wanted and resisted change. In this, the resistance that the organisation demonstrated within its various departments and hierarchies is commensurate with contemporary literature (Marshak, 2015; Bush and Marshak, 2016; Mathews and Linski, 2016). The inquiry's methodology provided methods and processes whereby communication with many stakeholders initially helped bring the percept into view, and thereafter led to the creation of the following percept.

The organisation participates in change

Representatives from across the organisation's hierarchy participated in all aspects of dual diagnosis service development, demonstrating the organisation's ability to change (Barrett,

2017; Rafferty and Jimmieson, 2017). These embedded service developments were in accordance with those illustrated in the dual diagnosis service's operational policy. As discussed, representatives from the organisation's area management team, including Clinical Nurse Managers (CNMs), and Psychiatry/Psychology Department Managers, participated both in the completion of this policy document and in many aspects of service implementation. The core tenet of such successful organisational change, as represented in this percept, is equally reflected in the literature (Hill et al. 2012; Aleksic et al. 2015; Bush and Marshak, 2016).

The invisibility of diagnosis in the service

From the initial point of referral into the service, where the individual was usually referred on the basis of a 'suspected' dual diagnosis, 'diagnosis' featured little, neither in the course of the inquiry, nor in the course of the individual's longer-term engagement with the service. From its emergence, however, while this independent percept neither hindered nor aided the inquiry/service development process, the invisibility of dual diagnosis in a dual diagnosis service warrants the exploration presented below. As a percept emergent in the inquiry, the invisibility of diagnosis is also represented in the literature, where in recent years, the use of the term dual diagnosis has shifted to that of complex needs (Roberts, 2010; Guest and Holland, 2011; Hamilton, 2014; Vanheule, 2017).

The service exhibits tangible change

Tangible change was demonstrated from Cycle One through to Cycle Three; hence, this percept was forming throughout the evolution of the change process. In this, tangible change was evident from the aspects of the service that became visible and embedded as the inquiry evolved. However, when it emerged in combination with other percepts as ends in view (Dewey, 1928; Martela, 2015) in Cycle Three, the complete realisation of this percept was brought to bear as more aspects of the new dual diagnosis service were solidly in place (Self and Schraeder, 2009; Hill et al. 2012; Raelin, 2012).

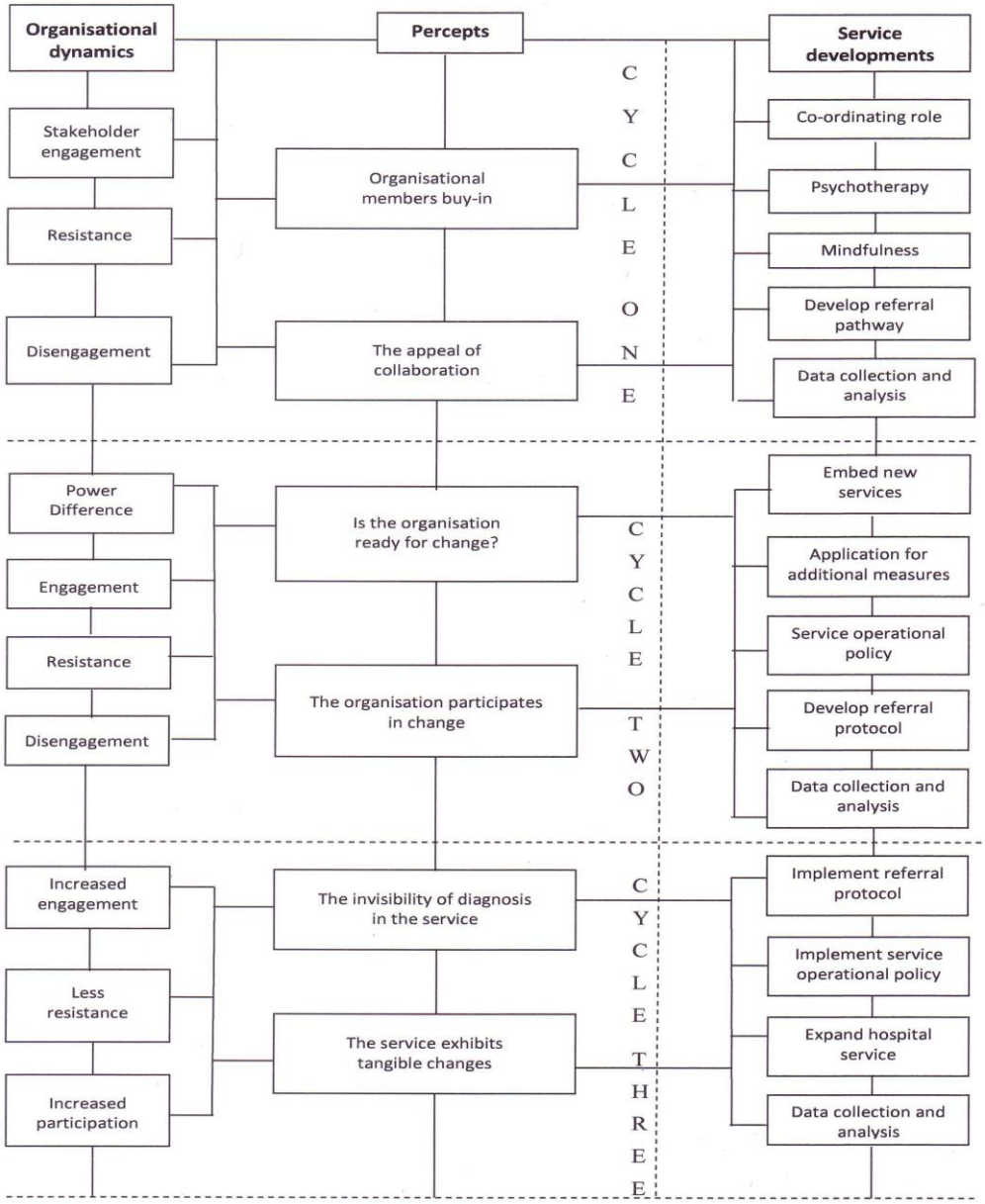

Figure 19. Correlation between organisational dynamics, percepts and service developments

A *primary thesis* is relevant to the particular context of the inquiry. The mental health and addiction services generally function independently of one another. While the integration of such ought to comprehensively respond to dual diagnosis, the literature review highlighted that integrating these independent systems is challenging. On this basis, I argued that the solution to integration was not only to be found in government-directed policy, but through implementing stakeholder-constructed policy in the practice setting. The organisational position I held was in a primary health care capacity. In conjunction with lead-researcher duties, including the additional interim coordinating role, the *hybrid* position enabled me to coordinate the co-construction of what evolved into a dual diagnosis service. The percepts were not unusual or new, and as isolated or combined entities in themselves they had not previously influenced any service change for this cohort. However, once these emerged within the context of this participatory process, the development and refinement of these percepts stimulated the evolving practical theory. The combination of any or all of these percepts described will no doubt further develop the dual diagnosis service in the future.

A *secondary thesis* contained within the first may suggest that collective knowledge is necessary for ongoing theoretical development. The percepts collectively suggest that the collaborative process is dependent on the participation of multiple stakeholders across the organisation's hierarchy. Where a broad range of stakeholders participate in developing and implementing a service operational policy, the democratic approach to such ensures that the aspects of the service required can be brought about through collaboration. From this, the practical theory that emerged from within this context is unlikely to be applicable to others, though the adopted methods that facilitated this theoretical development may inform other inquiries. Where representatives from various professional disciplines simultaneously function in hospital and community settings, their positioning can be pivotal in facilitating the integration of services across the organisation and the community. Although elements of resistance may emerge from time to time, this service development process has demonstrated that when there is an openness to such integration, both service-users and service providers can benefit.

Positionality

As the Cycles of inquiry highlighted, participants held diverse positions and responsibilities with the organisation and with the inquiry. My *hybrid* position in the organisation did not

change though, as discussed, while leading the research process, I assumed additional roles. With Cycle Three *ends in view*, as I consciously withdrew from the process in order to write the dissertation, other participants took over more leadership roles. As discussed with the core research group, apart from withdrawing from the process for writing purposes, I was also withdrawing from pivotal roles in the inquiry/service development process. This transitional period meant other participants agreed to take over these roles, though duties within the '*primary care*' position I held with the organisation would overlap with the service that had developed over the inquiry. In this, it was important for me, for the inquiry process and for the ongoing developing service that a clear timeline for my withdrawal was planned for. Upon agreement, three members of the core research group planned to share the duties I had assumed over the inquiry process, as the coordination of referrals and the facilitation of various groups, for example, blended well with the existing roles those participants held in the organisation.

The coordinating role was planned for early in Cycle One and became critical concerning its leadership function as the inquiry/service development process evolved. Figure 20 below illustrates the necessary roles and characteristics of leadership for the success and sustainability of such organisational change, according to O' Neill (2000).

Role	**Description**	**Hint**
Sponsor	Has authority to make change happen	Possesses vision for change
Sustaining Sponsor	Sponsors change in own area, although responsibility lies further up hierarchy	Must be careful not to transmit cynicism
Implementer	Implements change. Reports to sponsor, responsible for giving live feedback to clarify questions with sponsor on change progress.	Needs to listen, enquire and clarify questions with sponsor at start of initiative
Change Agent	Facilitator of change. Helps sponsor and implementers stay aligned. Keeps sponsor on board. No direct authority over implementers.	Acts as data gatherer, advisor, meeting facilitator, coach
Advocate	Has an idea. Needs a sponsor to make it happen. Usually highly motivated.	Must make idea appealing to sponsor.

Figure 20. Roles in a change process Source: (O' Neill, 2000)

Applying this framework to the inquiry context, the coordinating role was applicable to aspects of the *implementer*, the *change agent* and the *advocate* roles. While initially approved by the organisation (*sponsor*) to lead the research project, as *implementer* I frequently reported on ongoing service development and change. As *change agent*, I co-participated in aspects of service implementation and change throughout the Cycles, as I facilitated stakeholder engagement and gathered and analysed data. As *advocate*, I believe I was highly motivated in initially presenting my research proposal to the *sponsor*, who agreed to support the inquiry/service development found the idea of a dual diagnosis service appealing.

Cameron and Green (2004) highlight their experience in organisational development, where individuals across all hierarchical positions of organisations have found O' Neill's (2000) framework useful for beginning and sustaining change. The authors suggest this model provides clarity, especially as in this inquiry context, where the organisation's hierarchical structure may be unclear, and where departments, disciplines and functions overlap (Cameron and Green, 2004, p.139).

However, as I withdrew from the research process, the service was continually expanding with the need for additional resources being ever more pertinent. Core research group participants agreed that one learned understanding from communicating through varying hierarchical tiers was that the wheels of organisational change can be slow, though movement towards sustainability was certainly demonstrated in Cycle Three.

Participation as a process in PAR

One of the primary reasons in selecting PAR as the most suitable methodological approach to the inquiry was its potential concerning the participation of a broad range of stakeholders. Such potential for participation included individuals representing many areas of the organisation and the broader social world, within which the public mental health and primary care services function.

Following his comprehensive works on *Democracy and Education* (1899-1924), Dewey in *Experience and Nature* (1925/1988) generally describes human participation as a naturally occurring function in consciousness. He used the term participation '*to take part*' or '*to share*' in given situations, where commonalities could be drawn from human interactions in particular contexts:

> '*…that an individual, possessed of some mode and degree of organised unity, participates in the genesis of experience of every experienced situation, whether it be an object or an activity, is evident*' (p.189).

Considering the percepts that emerged from stakeholder participation in the inquiry process, the human cognitive-sensual functions that brought about those percepts could be interpreted as being synonymous with participation, as Dewey states, *to par-take* and *to perceive* (p.259). Emergent from perspectives of critical theorists including Habermas (1987), contemporary theorists Webler and Tuler (2001) identified two forms of public participation, that is, *sustained deliberation* and *power-sharing*. While challenges generally remain in realising either form of public participation, the application of *sustained deliberation* appears to be suitable to some public fora, while *power-sharing* may be more applicable to others. Drawing on Dewey's broad work about context, the selected communicative approach towards empowering people within this *power-sharing* process was the most appropriate to this particular context. Within this approach, Webler and Tuler (2001) illustrate two principle ingredients, *fairness* and *competence*.

Fairness pertains to the collaboration of individuals within a fair decision-making process which includes possibilities to:

- *attend (be present);*
- *initiate discourse (make statements);*
- *participate in the discussion (ask for clarification, challenge, answer and argue);*
- *participate in decision-making (resolve disagreements and bring about closure).*

Competence includes reaching the best level of consensus that stakeholders can collectively know about at a particular point in time, requiring the fundamental components of:

- *access to information and its interpretations; and*
- *use of best available procedures for knowledge selection* (p.182).

Relative to this inquiry, the divergent and iterative process of participation in decision-making seemed to constitute what Webler et al. (2001) described as a good participative process:

1. *A good process considers matters of legitimacy through agreed decision-making.*
2. *A process that enables ideological/democratic discussion among a core group of stakeholders.*

3. *A process that is transparent and fair, whilst achieving participation from all realms of the community.*
4. *A process that considers the dynamics of power amongst stakeholders.*
5. *A process that highlights leadership roles including the input and debate from diverse community stakeholders' perspectives* (pp.441-445).

While participation within the inquiry fluctuated, Webler and Tuler's (2001) elements of *fairness* were achieved by way of active-inactive and formal-informal means of engagement. For example, participants attended and actively participated at various times in the core research group, where their participation in decision-making was instrumental to the inquiry process. Where the adopted worldviews of PAR and pragmatism enabled participants to engage freely with the process of inquiry, participation was both formal and informal in accordance to participants' motivation to participate at a given time. Meeting the components of *competence* within the inquiry, which included multiple stakeholders representing many competing disciplinary/societal cultures, was less clear. Multiple stakeholder participation in developing the service operational policy was a vivid example of how access to and interpretations of the best available information for collectively selecting and generating knowledge was realised in constructing the document. Within this fourteen-month collaborative process, the elements of a good participatory process as outlined by Webler et al. (2001) were largely met. Further out from the inquiry nucleus, more informal participation, where individuals diversely interacted across the organisation, appeared less likely to influence such selected decision-making.

The synergy of PAR and pragmatism

Aligning with the worldviews of PAR and pragmatism, Gustavsen (2001) proposes a pragmatic perspective on participation through dialogue, suggesting that pragmatic outcomes can be gleaned from the inclusion of the following criteria in participatory approaches to inquiry:

1. *The dialogue is based on give and take as opposed to one way conversation.*
2. *All people concerned by the issue under investigation should have the opportunity to participate.*
3. *Participants are obliged to help other participants be active in dialogue.*
4. *All participants have the same status within the dialogue arena.*

5. *Experience is the point of departure for participation.*
6. *At least some of the experience the participant has when entering the dialogue is seen as relevant.*
7. *It must be possible for all participants to have an understanding for the topics under discussion.*
8. *An argument can be rejected only after an investigation (and not for instance, on the grounds that it arises from a source with limited legitimacy).*
9. *All arguments to enter the dialogue must be represented by the actors present.*
10. *All participants are obliged to accept that other participants may have better arguments than their own.*
11. *Among discussion issues can be the roles occupied by participants with no one exempt from such a discussion.*
12. *The dialogue should be able to integrate a growing degree of disagreement.*
13. *The dialogue should continuously generate decisions that provide a platform for joint action* (p.89).

All of the above criteria were met within the formal groups held during the inquiry, though considering no. 4, all participants in the psychotherapy group may not agree that facilitators held similar status to service-users, while the inquiry approach did not set out to measure whether such observations were accurate or not. Likewise with informal participation, as participants interacted across the hierarchical organisation, maintaining equal status was not possible. For example, regarding no. 8, it was not always possible to settle differences outside of formal participation, such as when medical staff disagreed with the regular presence of the acupuncturist on the acute unit.

Gustavsen's (2001) pragmatic approach focuses more on participation as '*a relationship-building event*', wherein pluralist perspectives enable the contribution of all participants to be valued as part of the full story. This was a central component to the inquiry where service-users and organisational members collaborated in a process that included representatives from across the hierarchy, whose participation was both varied and valued. With such levels of participation within the hierarchical structure of an organisation, varying positions can represent diverse levels of influence or power. While individuals may perceive power differently, depending on their subjective levels of participation or relationship with the

organisation, Chinn (2004) suggests that those subject to such may perceive '*power-over*' structures as '*the only way*' (p.12). In contrast to '*power-over*' powers, the author explores the underlying values of what '*peace-power*' can include within the exercise and use of power, especially when collaborating with others towards a shared objective, as in this inquiry. Considering these dynamics, this process of participation ultimately co-constructed a dual diagnosis service that may otherwise not have been possible if a more rigid-hierarchical approach had been taken. This participatory process embraced elements of what *peace powers* constitute, where '*the values that form the foundation and intentions of the process symbolise the spirit and intentions that energize the process*' (Chinn, 2015, p.63). The author suggests that participants ought to consider such contrasting types of power in the collective creation of balancing such power differentials.

Power perspectives

The process as outlined in *Peace and Power* (Chinn, 2013c) is employed widely by groups within public health agencies seeking peace (individual's inner peace and peaceful interactions within a group) and power (empowering all), whilst collectively aiming to achieve shared objectives. At the heart of the *peace and power* process is what Freire (1970) refers to as praxis, that is, reflecting and re-reflecting on the values that stimulate the actions of a group, continually creating and re-creating actions and interactions to reflect such values. Chinn's (2015) theoretical framework of *Peace and Power* provides (i) the actions that make the theory and values visible and perceivable, and (ii) an explanation for the outcomes that emerge from adopting this approach to group participation. The following summarises the components of a participatory process, in which the actions highlight the values on which the process is based.

Process	***Description***
Principles of solidarity	*Formed by group to represent their shared values and commitments, essential as a foundation for all other components of the process.*
Check-in	*Each person speaks briefly to share your ability and commitment to participate in the process, and expectations for the time the group is together.*
Rotating leadership	*Everyone participates as leader and follower. Leadership roles rotate. Skills/knowledge shared.*
Value-based decisions	*Decisions based on principles of solidarity.*

	Minority views encouraged. Decisions selected from mutual agreement.
Conflict transformation	*Critical reflection processes to ground understanding.*
Closing	*Each person shares appreciation for specific actions, critical reflection on future plans. Personal affirmation that that connects one's own intentions with that of the group.*

Figure 21. Peace and Power processes. Source: (Chinn and Falk-Rafael, 2015, p.64).

While the language used in the *Process* side above does not reflect that used in this inquiry, the components included under the *Description* column do reflect the actions and processes that occurred in and between participants. The core research group forum was a clear example of a participatory process that facilitated active participation of multiple stakeholders in a critically reflective process. Furthermore, facilitator roles rotated, while emphasising the input of both service-users and service providers, who in other contexts may have exercised varying degrees of power. Chinn and Falk-Rafael's (2015) theoretical framework of *Peace and Power* is based on the following assumptions, reflecting how power can be variably exercised in the public and private domains:

1. *Human interactions inevitably include power and in varied ways. Though power can be used over others to serve those in positions of power, rather than the collective interests.*
2. *Usually within an organisational structure, there are individuals or groups that have more power privileges than others; these may exert such power on those less empowered. Successful groups discover ways to balance such differentials.*
3. *In life, individuals generally pursue a space that is free from struggle and power imbalances, the home often representing such. Associated with the power and influence of the woman, the 'home' comfort values include love, affection, sharing, peace, mutual decision-making, etc.*
4. *In the western world, male power is more often associated with the public and capitalist arena, where self-will, strength and power pursue competitive advantage over others, where even democracies represent the majority over the minority. While*

some participatory processes attempt to address such imbalances – allowing the voices of the minority to be heard, the status quo suggests that those in power exert such on others.

5. *While conflict is an element of human interactions, if the collective desire is present, the individual and the group to grow towards positive change.*
6. *Drawing from what is generally expected as normal in private life, contemporary social trends suggest that individuals acknowledge the value of collaboratively working together in the public domain. In this, people experience greater satisfaction when more involved in the process.*

Adapted from Chinn and Falk-Rafael (2015, pp.63-64)

The theoretical concepts of *Peace and Power* according to Chinn and Falk-Rafael (2015) are summarised here: '*Power is the energy from which human action and interaction arises*' (p.64). As individuals bring their experience from private and public domains into group contexts, this learned experience will influence their actions and interactions in both the home and workplace, for example. In public realms, many *power-over powers* are exercised and can include competition, rules and deadlines, for example, while in the home or private realm, *peace-powers* can include sharing, collective decision-making and diversity. As both types of power can exist in either realm and the elements from each can overlap, the difference between the powers that present in private or public contexts seems to depend on what is valued the most in each particular realm. The authors emphasise that where tension between contrasting powers arises in groups that it is through the acknowledgement and working out of such differences that the path towards peace is paved. Where groups work within a peace-power framework, individuals, whilst being aware of each subjective experience of various power experiences, work towards mutually constructed actions founded on peaceful intentions. The outcomes of a *Peace and Power* group aims at fulfilling the sub-concepts of *Peace,* which, according to Chinn (2013c), include praxis, empowerment, awareness, cooperation and evolvement, the elements of which have been very much present throughout this participatory process.

The contrasting features of power positions include:

Power-Over Powers	***Peace Powers***
The Power of Results	*The Power of Process*
The Power of Prescription	*The Power of Letting Go*
The Power of Division	*The Power of the Whole*
The Power of Force	*The Power of Collectivity*
The Power of Hierarchy	*The Power of Solidarity*
The Power of Command	*The Power of Sharing*
The Power of Opposites	*The Power of Integration*
The Power of Use	*The Power of Nurturing*
The Power of Accumulation	*The Power of Distribution*
The Power of Causality	*The Power of Intuition*
The Power of Expediency	*The Power of Consciousness*
The Power of Xenophobia	*The Power of Diversity*
The Power of Secrets	*The Power of Responsibility*
The Power of Rules	*The Power of Creativity*
The Power of Fear	*The Power of Trust*

Figure 22. Contrasting power positions. Source: (Chinn, 2004, pp.12-15).

Many of the *peace powers* that emerged in the action-oriented context of this inquiry seem to have positively influenced this participatory process. This was demonstrated throughout the inquiry process where, for example, the *Power of Collectivity* valued each individual's input in the core research group as central to the collective inquiry. Furthermore, decisions from within the core research group were perceived as being more appropriately pragmatic than a decision made by any one individual. The *Power of Integration* was evident in all elements of the inquiry. Respect was acknowledged for the integration of every individual's right to make their own decisions in the overall process. The *Power of Diversity* embraced alternative perspectives, stimulated creativity and motivated flexibility where everybody's point of view informed decisions, with diverse perspectives encouraged and expressed. The *Power of Process* epitomises a different perspective and freedom from rigidity. Aims and objectives,

programmes and time schedules were used as tools, though had less importance to the evolving collective process of the dual diagnosis service development itself.

Co-participation of service-users and service providers

It was a success of the inquiry that service-users and organisational employees participated together in the construction of this service. The World Health Organisation (WHO, 2010) encourages mental health professionals to adopt a recovery paradigm, including agency, empowerment and service-user participation in service development (Deegan, 1988, 1990; Anthony, 1993; Deegan, 1993; Linhorst et al. 2005; Mental Health Commission Ireland, 2008). As discussed, service-user participation in research can have various levels occurring along a continuum, drawing from Arnstein's (1969) initial theory of citizen participation. In this typology of levels of participation, Arnstein illustrates eight rungs of a ladder (Figure 23 below). The first bottom two, *manipulation* and *therapy* are levels of *non-participation*, where individuals may engage in some activities, though where those in power aim to *control* or *cure* participants. Rungs three, four and five as shown below enable participants' voices to be heard, though whose power may be eroded by more powerful or dominant decision-makers. The last three rungs enable participants to negotiate and authentically engage with those traditionally in power-holding positions. While Arnstein (1969) acknowledges its simplistic typology, the eight rung ladder nonetheless describes the variations of citizen participation that can help understand both demands for increased participation by those in traditionally less powerful positions, and for those in more powerful positions who may not be accustomed to such participation (pp.216-217).

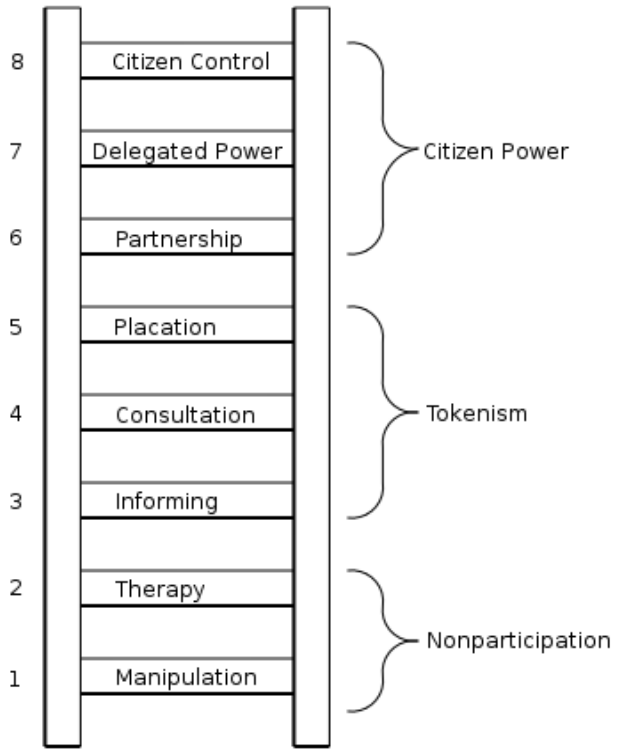

Figure 23. Ladder of participation: Source: (Arnstein, 1969)

While service-user participation in mental health services has been taking place for some time, (Thomas and Bracken, 2004; Gabbey and le May, 2011; Smith-Merry et al. 2011), there is little evidence of service-user participation in the context of dual diagnosis service development (Drake et al. 2006; McDaid, 2006; Hind and Manley, 2010; Place, 2010). However, as a contribution to knowledge in this regard, this inquiry has demonstrated that service-users have actively participated in planning, decision-making, implementation and reflection processes. Thus, considering Arnstein's (1969) typology, service-users have accessed various rungs of the ladder throughout the inquiry, authentically participating with those service providers who may otherwise assume greater levels of power.

While the methodology facilitated the co-participation of multiple stakeholders, the participation of service-users fluctuated, as did the participation of staff. In some formal groups, staff out-numbered service-users, whereas in other groups' service-users out-numbered staff. Likewise, service-users seemed to engage or disengage in the inquiry in accordance to the level of participation they wanted at any given time, while the participation

of staff seemed to be no different. However, as the core research group forum was where the majority of decision-making took place, the participation of staff over the inquiry was greater than the participation of service-users. Even though all decisions made in that forum were ultimately presented to service-users, the balance of power could be perceived as unequal in the decision-making process, despite service-users being continually invited to participate. While the experience of the diverse and fluctuating participation in this inquiry were context-specific, this PAR process has nonetheless demonstrated service-user participation *with* organisational members in the developing health-care environment of Primary Care in Ireland, aspects of which may contribute to future organisational dual diagnosis service developments.

The feature of *Dual Diagnosis* within the inquiry/service development process

As discussed, the inquiry took place within the organisational and environmental context of primary and mental health care services, which by their nature function within professional discourses and employ associated terminology and language. Through the influence of varied academic and disciplinary training routes, organisational employees generally interact in and between disciplines/services via a common 'professional' language. Even though many inquiry participants represented this 'professional' group, the use of professional terminology featured little over the inquiry process. There is, of course, no question that the use of professional terminology is inappropriate; on the contrary, within the processes of assessment and diagnosis, the adoption of such is pertinent to decision-making and safeguarding the service-user's particular concerns (DOH, 2007). What can become blurred and potentially invasive (Bergmann, 1992) is if such professional language is imposed upon an individual who newly presents at the organisation and inevitably encounters the discourse within which it functions. In the context of psychiatric discourse, Vanheule (2017) suggests, the use of such language '*triggers a network of beliefs and societal practices….which is inevitable when a discourse becomes dominant and simply taken for granted*' (p.36).

Within the formal inquiry groups and in informal interactions throughout the inquiry, the use of professional language did not seem to largely occur, or, if it did, did not emerge as a concern for participants. Even though service-users invariably discussed particular diagnoses, including related concerns and medications, for example, many of these conversations appeared to be conducted using everyday language. The use of the term 'dual diagnosis' was

utilised in almost all referrals from mental health and primary care services over the course of the inquiry. However, from that point onwards, the term appeared to be rarely used by 'professionals' in their interaction amongst themselves, while in day-to-day interaction with service-users it did not seem to feature at all. This would suggest that the term may be appropriate to the initial assessment and diagnostic process, and perhaps in the subsequent referral, in that it gets the individual to the appropriate service. The term may also be effective in its use for documentary and research purposes, as in this inquiry (Connolly et al. 2015). However, in other contexts, the term 'dual diagnosis' appears to lack efficacy in the day-to-day interactions with those experiencing complex needs, many of which include substance use and psychological distress (McKeown, 2010; Roberts, 2010; Guest and Holland, 2011; Hamilton, 2014).

However, while the term dual diagnosis may inevitably invoke ambiguity within the surrounding discourse, its selection in this inquiry was on the basis of its broad use in research and practice internationally (CSAT, 2005, 2006, 2007; Drake et al. 2007, 2008; Hunt et al. 2013) and in its reference to the co-occurrence of mental health and substance use concerns (Lehman et al. 2000; Ziedonis et al. 2005; Wakefiled, 2013). Furthermore, within the clinically led hierarchical-organisational context of this inquiry, diagnosis as a function and as a process is of particular importance to appropriate treatment planning for individuals presenting with such complex needs (Jacobs et al. 2005; CSAT, 2007a; McKeown, 2010; Wakefield, 2013; Vanheule, 2017).

Overview of broader historical context

As discussed in depth in the literature review, the awareness and response to dual diagnosis has been recognised internationally for some time (Weiss et al. 1992; Watkins et al. 2001; DOH, 2002; Rush et al. 2008; DOH, 2009; Baldacchino and Crome, 2011), whereas within the Irish context, it is only relatively recently that it has featured in the literature (MacGabhann et al. 2004, 2010; Government of Ireland, 2009; Connolly et al. 2010; Government of Ireland, 2012; Connolly et al. 2015; Garbare, 2015). The evolution of dual diagnosis services in Ireland continues to be managed within both mental health services and addiction services respectively. The Department of Health holds responsibility for policies and planning for mental health services (Government of Ireland, 2006; Expert Group on Mental Health Policy, 2009; Department of Health, 2012), and since 2011 the Department of Health also holds

responsibility for the coordination and implementation of the National Drug Strategy (Government of Ireland, 2009). Considering policy developments concerning dual diagnosis, the *Vision for Change* (Department of Health and Children, 2006) recommended:

> '*Mental health services for both adults and children are responsible for providing a mental health service only to those individuals who have co-morbid substance abuse and mental health problems*' (p.149).

Three years later, the *Vision for Change Implementation Plan: 2009-2013* suggested resources may be made available for addiction services, though meanwhile the mental health services have not received any such focused resources. While dual diagnosis features in varied policy documents for both mental health and addiction services, no Irish government policy on dual diagnosis has emerged (MacGabhann et al. 2010). However, in the absence of national policy direction, services such as those within this inquiry have developed initiatives to respond to dual diagnosis (Connolly et al. 2015). In order to respond effectively to dual diagnosis, whilst drawing from leading international resources (Bateman and Tyrer, 2002; CSAT, 2005, 2007a, 2007b, 2007c, 2007d; Croton, 2007; Todd, 2010), the integration of assessment, diagnosis and treatment planning is required. While these interventions have been previously individually explored, their application to this inquiry and the development of the service is discussed here.

Assessment

As illustrated in the inquiry process, the individual's initial engagement with the dual diagnosis service has been in both hospital and community-based settings. In both, the initial process of assessment usually commences with general observations, substance use withdrawal and treatment of acute mental health symptoms. In this phase, the possible relationship between the individual's substance use and mental health concerns is considered. Also, the improvement or not of mental health symptomology during the detox process is essential to planning appropriate treatment (Lehman et al. 1989). Equally pertinent at this phase is the assessment of risk, the principles of which according to the Department of Health (2007) include:

- *Risk cannot be completely eliminated.*
- *Risk can be general, specific or both.*

- *Risk is dynamic, changing over time.*
- *Judgement is not absolute; clinical judgement does not completely determine an individual's level of risk.*
- *A team approach ought to be adopted in measuring risk.*
- *Upon identification, risk must be managed.*

  Department of Health (2007)

With the detox phase completed and where an individual's mental health symptoms have completely receded, where there is no history of mental illness, a dual diagnosis is not likely. However, where the detox is completed and mental health symptomology remains, particularly where there is historical mental illness, then dual diagnosis is probable (Castel et al. 2006; Holt et al. 2007). The multi-disciplinary approach to assessment in this inquiry included the psychiatrist, psychologist, mental health nurse, occupational therapist, addiction counsellor, social worker. The benefits of this integrated approach to assessment were demonstrated in findings from Cycle One, Cycle Two and Cycle Three, and are equally reflected in the literature (Kavenagh et al. 2003; Mueser et al. 2003; CSAT, 2007a; Sacks, 2008).

Practitioners utilised a variety of standardised assessment tools (as outlined in the service's operational policy guidelines, Appendix J.), which were effective in both collecting pertinent data and in interactively engaging with the individual (Banjeree et al. 2002; Teeson and Proudfoot, 2003; Yager, 2015). This process of interaction with the individual evolved over the course of the inquiry and involved many practitioners in various settings. In this, the assessment was comprehensive and conducted over a period of time (Bateman and Tyrer, 2002; NTA, 2006a, 2006b). Interacting with the individual over various periods of time and in the various settings described allowed Prochaska and DiClemente's (1983) model for assessment and treatment, outlined below, to be adopted. In the context of addressing one's substance use and where motivation is considered a precondition for change, practitioners have found this model helpful:

- *Pre-contemplation*, where one does not acknowledge the nature or extent of the problem.

- *Contemplation*, where one recognises there is a problem, and that change may be necessary. The individual explores the problematic substance use, though may be ambivalent about change.
- *Decision*, where one decides or not to make changes.
- *Action*, where a plan of change is co-constructed.
- *Maintenance*, where the changes are acknowledged, consolidated and developed.
- *Relapse*, where one returns to previous stages of change, with support structures put in place to return to desired state of change.

Prochasake and DiClemente (1983)

Because of the multi-disciplinary approach to assessment that evolved over the inquiry, practitioners' adoption of this practical model helped clarify for all concerned the stage the individual was at throughout their engagement with the dual diagnosis service. This collaborative team-based approach enabled focus to remain on the individual's treatment needs according to the stage of change the individual was experiencing at any particular time. Any diagnoses that may have been made at earlier stages of the assessment process appeared to feature little over the course of the individual's engagement with various aspects of the service, nor did diagnosis feature in the process of inquiry/service development. When it did feature, it was usually in the earlier phase of engagement when the individual had questions concerning medication effects and/or changes, while practitioners rarely used diagnostic related terminology in their day-to-day interactions concerning the care, well-being and treatment for the individual concerned.

However, after the initial assessment and diagnostic process takes place, the absence of 'diagnosis' over the course of the individual's engagement with this dual diagnosis service may have implications for further research and practice in this domain. Much of the discourse relating to 'diagnosis' (being institutionally situated) highlights formal elements of precisely stated and carefully limited claims based on statistical evidence, including that of the DSM-V (APA, 2013). It is equally recognised, however, that much of the diagnostic procedure also depends on more informal or less replicable elements (Faber et al. 1996; Wigman et al. 2013; Vanheule, 2017).

Diagnosis

According to Harper (2011), the concept '*diagnosis*' (from the Greek '*diagnoskein*') refers to '*discern*' or to '*know thoroughly*'. Traditional psychiatry, according to Vanheule (2017), was less concerned with '*developing thorough knowledge*' of an individual's mental suffering, but focused rather on differentiating between various mental disorders (p.13). Furthermore, the DSM appears to link diagnosis with classification, and in the process largely ignores the individual's '*global functioning*', a deficit that remains questionable if categorisation is deemed to enable an accurate description on one's mental health (p.14).

Webb (2010) suggests that '*at best the scientific status of the current diagnostic system of modern psychiatry is that it is a hypothesis*' (p.32). Nevertheless, the formal diagnostic process (DSM-V) is a central component to the assessment conducted by those working in the medical model of health care practice, which responds to those experiencing complex needs within this organisational context. The various tenets of the diagnostic process are discussed here, considering the realm from where the social and the scientific merge.

Diagnosis can be seen as serving two functions:

1. A referential function, where the aim is to provide as neutral and objective an evaluation as possible, largely tentative in its claims with the basis and criteria for such claims clearly highlighted (Frances, 2013). The discourse here is formal and scientific, which renders findings transparent and contestable in a way that more subjective evaluations would not be. Subjective judgment on the part of the practitioner is not involved (Verhague, 2002, 2014).
2. An injunctive function, the interpretations and recommendations offered in respect of the more formal diagnosis referred to above include real effects in the real world. Such recommendations will be expected to adhere to the evidence provided by the formal scientific findings but, as suggested, such findings tend often to be modest rather than definitive in their claims, which can allow for a wide range of treatment options. In this, the practitioner will tend to make subjective judgement in accordance with their expertise and the specific relevant contingencies (Vanheule et al. 2014; Yager, 2015).

Of note, the diagnostic classificatory assessment itself is conducted partly along formal lines (standardised tests) and partly according to more subjective observations, both those of the presenting individual (through responses to selected instruments/questionnaires), and those of the practitioner (through observations, for example). In adherence to mental health service policy, instruments used in the initial assessment process over the course of the inquiry are outlined in the service operational policy document (Appendix J).

> '*Many of us assume that all questions to which scientists address themselves admit of a definitive answer once the evidence has been assembled. If we want to know whether schizophrenia has a genetic basis, for example, we assume we can simply collect the data, see what they say, and move on to the next question. This common sense view of how science works probably comes from high school science courses, which represent the field about as well as civics courses represent what actually goes on in politics. We were never taught about controversies over how a scientific dispute is to be framed, the various uses to which certain terms are put, the debates over the applicability and significance of particular findings. Data are not simply collected but interpreted, and how they are interpreted depends on what is counted as evidence as well as one's positions on other theoretical questions*'
>
> Kohn (1992, p.14)

In other words, while the referential (formal) aspect of the diagnosis lays claim to objective scientific authority, the injunctive (informal) aspect depends on an act of personal judgement made with sensitivity to the specifics of the individual's presenting situation. The practitioner's findings may be influenced not only by '*what is counted as evidence as well as one's positions on other theoretical questions*' (Kohn, 1992, p.14), but by various other factors, potentially including discontinuing employment and drug seeking, which will perhaps lead to a particular diagnosis. The framing of such a diagnosis will consider both the objective scientific findings and the real world context.

Also influencing recommendations may be the limited or broad selection of treatment options available, and particular treatments or indeed diagnoses that may be currently or locally in vogue (Showalter, 1998; Harwood, 2010). Ultimately it is likely that the practitioner's diagnosis will be made not in a purely abstract and academic frame of mind, but with full consciousness and sensitivity to the practical context. Rather than the practitioner neutrally and arbitrarily applying an impersonal scientific calculation, they will tend to forge a

connection between the scientific findings and by the individual's circumstances at that particular time (Verhague, 2002; Hyman, 2010; Bastra and Thoutenhoofd, 2012).

Harvey (2016) refers to how '*we are thus forced to confront directly in the social sciences what arises only indirectly in the natural sciences, namely the social bases and implications of control and manipulation*' (p.14).

As Harvey suggests, this can often lead to the accusation that '*the social sciences are indeed in a pre-scientific state*' (p.16). 'What this does suggest, however, that the natural sciences are in a pre-social state…..the consequent moral dilemmas for those scientists who take their social responsibility seriously are real indeed. Contrary to popular opinion, it seems appropriate to conclude that the philosophy of social science is *potentially* much superior to that of natural science and that the eventual fusion of the two fields of study will come about not through attempts to *scientise* social science but instead by the socialisation of natural science. This may mean the replacement of manipulation and control with the realisation of human potential as the basic criterion for paradigm acceptance' (p.17, author's italics).

Such realisation of human potential is unfortunately generally not visible at the time an individual chaotically presents at mental health services because (i) emergency intervention is generally required; (ii) only limited information is available at that point; and (iii) the individual is at that point often incapable of participating in the dialogic process as an authentic agent. What usually happens is that procedures are formally put in place to explore further options as the crisis eases, the individual becomes more capable of providing significant information, and the individual develops potential to verbally participate as an authentic agent (Verhague, 2002).

The interpretation of the diagnostic findings in the acute phase will generally involve a related selection of treatment procedures together with a monitoring of the effects of such via observation and interview and consequent modification. This approach frequently succeeds in limiting some of the negative consequences of what is perceived as the presenting problem, but that does not imply any success whatever in actually resolving that perceived problem. For example, a sleeping pill does not resolve any psychological causes of sleeplessness, nor does Viagra resolve any psychological factors inhibiting sexual arousal or consummation. To resolve such issues, one requires at the least the relevant information, both historical and of a

discursive variety. Very often, however, even the requisite information of the most basic historical kind is lacking during the diagnostic process, as the individual may be embarrassed, has repressed or lacks the capacity at that point to articulate. The therapeutic (individual and group therapy) and socially supportive (occupational therapy/nurse support) aspects of this new dual diagnosis service provide access to a necessary space to liberate such vital information. Over the course of the inquiry, service-users provided new and different information the longer they were engaged with these supports, compared with the limited information when they were originally diagnosed. In general, service-users who can authentically engage and relate in therapeutic supports tend to obtain access to insights previously lacking to them, and therapy offers a space where such insights, often challenging or alarming on initial encounter, can be safely, effectively and rewardingly assimilated. The individual's capacity for benefitting from such insights is a very significant factor affecting any evaluation or formal recommendation (for example, regarding optimal treatment).

But this factor (the individual's capacity for benefitting from such insights) cannot be completely taken into account at the time of initial (emergency) diagnosis, as they are not in a position at that juncture to access or benefit from such insights. On this basis, while the formal diagnosis is essential to safeguarding and managing the individual's initial engagement with the services, many of the circumstantial variables at the diagnostic stage are invariably omitted. From this experience with service-users over the inquiry process, it appears that when the formal diagnosis and the informal variables are eventually collated, that the merging of the social and the scientific collectively provides an understanding of what the individual's complexities actually are. Furthermore, the fact that diagnosis did not feature over the inquiry process once the initial diagnosis was made may suggest that the therapeutic emphasis shifted from the scientific classification of the presenting symptoms (diagnosis), to a longer-term exploration of the social variables (extended MDT assessment and treatment).

Developing a service within competing paradigms

As discussed in the Introduction chapter, the mental health and addiction services and the disciplines, services and social/educational supports that function within these and throughout the broad environment of primary care, include paradigmatic discourses that both converge and compete in various ways. In practice, however, incompatible and/or competing paradigms, because of their nature, may have previously restricted or continue to inhibit

access to services necessary for those experiencing complex needs. For instance, one goal within the HSE's *Operational Plan for Cork and Kerry* (2016), includes '*the implementation of a dual diagnosis project between addiction services and mental health services for clients with a dual diagnosis*' (*Goal 2. Social Inclusion, Primary Care*. p.68).This is progressive, as it builds on previously implemented Dialectical Behavioural Therapy (DBT) programmes (and various adaptations of this therapy) that have been successfully implemented within specialist addiction services locally in recent years. Such DBT responses to dual diagnosis include the integration of the addiction services and mental health services, in the context of both the department and discourse of psychology, within which such programmes are developed and managed. While many experiencing dual diagnosis undoubtedly may benefit from such interventions, many may not be able to access such structured and time-limited programmes because of their complex needs (Horsfall et al. 2009; Rosenthal et al. 2012). Furthermore, as discussed, the discourse shift from dual diagnosis to that of complex needs (Roberts, 2010; Guest and Holland, 2011; Hamilton, 2014) suggests the growing awareness amongst service providers of the myriad complexities experienced by this cohort. From this, the ongoing developments of psychological oriented discourses that focus primarily on mental health diagnoses and related addiction concerns are indeed very welcome. However, as in this inquiry, when service-users engage with multi-disciplinary and multi-departmental services and social supports, as long as they need or want to, all potential subjective complexities, including medical, housing, legal, family/relationship issues, can be simultaneously addressed (NICE, 2016).

However, within a multi-disciplinary team-based approach to such complexities, as this inquiry process has demonstrated, it is through integrated dialogue that previously incompatible or competing discourses become more accessible. This integrative process on the ground has effectively informed the embedding of the new dual diagnosis service, guidelines on which are illustrated in the collaboratively constructed dual diagnosis service operational policy (Appendix J.). On this basis, considering the lack of Irish government policy concerning guidelines on dual diagnosis service delivery (MacGabhann et al. 2004, 2010; Garbare, 2015), the contents and efficacy of this locally developed policy may inform or have implications for future policy development. In essence, where an organisation that operates within competing discourses and paradigms but yet is open to change, it is possible

to provide a diverse range of services according to those competing discourses and paradigms, just as this dual diagnosis service development has succeeded in doing.

Implementation dynamics of organisational change

The successful embedding of the various aspects of the new dual diagnosis service has been demonstrated throughout the Cycles of inquiry, the outcomes of which are evident in the findings emergent from each Cycle. However, implementing this change within the hierarchical organisation has encountered challenges which are consistent with organisational change generally (Cameron and Green, 2004) and in particular within healthcare environments (Ziglio et al. 2009; Evans et al. 2011; Herald et al. 2012). As a backdrop to organisational change theory, Morgan's (1986) use of the following organisational metaphors provides a broad view of what assumptions can exist concerning such change:

- *Machines*
- *Organisms*
- *Brains*
- *Cultures*
- *Political systems*
- *Psychic prisons*
- *Flux and transformation*

> '*Metaphor allows us to deepen our understanding…allowing us to see things in new ways… Metaphor allows us to create distortions too…..we have to accept that any theory or perspective that we bring to the study of organisations….while capable of creating valuable insight…..is also incomplete, biased and potentially misleading.*'
>
> Morgan (1986, p.39)

For example, one of the above metaphors, *flux and transformation* fits with the complexities and dynamics that emerged within this organisational change process. For example, this perspective views life within organisations as being part of the general environment as opposed to being separate from it (Shaw, 2002). This perspective further enables organisational life to be understood from the ever-changing complex environment within which it functions, where no one is ever in a position of total control over the design and

implementation of proposed changes (Morgan, 1986, pp.5-7). Beliefs from the *flux and transformational* perspective include:

- *Order naturally emerges out of chaos.*
- *Organisations have a natural capacity to self-renew.*
- *Organisational life is not governed by the rules of cause and effect.*
- *Key tensions are important in the emergence of new ways of doing things.*
- *The formal organisational structure (teams, hierarchies) only represents one of many dimensions of organisational life.*

These key beliefs lead to these guiding principles:

- *Change cannot be managed, it emerges.*
- *Managers are not outside the system they manage, they are part of the whole environment.*
- *Tensions and conflicts are important feature of emerging change.*
- *Managers act as enablers, they enable people to exchange views and focus on significant differences.*

Cameron and Green (2004, p.92)

Elements of these beliefs and principles have been evident within this PAR inquiry/process of organisational change, where various teams, hierarchies and the organisation's service-users have co-participated in new ways of responding to dual diagnosis. While this process included resistance, the iterative emergence of implemented change, demonstrated through findings emergent from each Cycle of inquiry, signified that within such organisational flux the organisation had the capacity to change. While Lewin's (1946/1997) cyclical model of change was applicable to this particular context, the following theoretical perspectives may also be applicable to healthcare settings. Diffusion theory (Rogers, 2003), for example, identifies three broad characteristics related to an organisation's readiness for change: *individual, internal* and *external*. Within these categories, sub-variables include the organisation's size and leadership qualities which impact on the organisation's capacity for change. An overview of the variables identified by Rogers (2003) include:

Variable	***Description***
Size	*Size of the organisation is related to the propensity for change.*
Centralization	*Refers to concentration or locations of power.*
Complexity	*Refers to knowledge/expertise levels to bring about change.*
Formalisation	*Refers to organisational bureaucracy promoting change.*
Interconnectedness	*How individuals are connected inform the change process.*
Organisational slack	*Refers to resource availability to sustain change.*

Rogers (2003, pp.96-98)

According to Rogers (2003), organisations go through the various stages as part of the planned change, with the rate of implementation determined by how compatible the innovation is with the values and experiences of the organisation's social system. For example, in an application of Rogers' theoretical framework with the objective of increasing healthy eating and physical activity amongst an organisation's employees, Gates et al. (2006) identified both individual and workplace barriers that inhibited possibilities of implementing that planned change. Outcomes from that study identified that the organisation may not have been ready for change.

One of the percepts that emerged during this inquiry concerned the organisation's readiness for change. The emergence of this percept was on the basis of participants' demonstration of resistance to the organisational change that was becoming evident at that time. Experts in organisational change management have highlighted the significance of establishing organisational readiness for change and have recommended particular strategies for creating such readiness (Armenakis, 1993; Amatayakul, 2005; O' Connor, 2006). For example, assessing organisational readiness for change, according to Warner (2009), '*is a critical precursor to implementing change in healthcare settings*' (p.2). While assessing this organisation's readiness for change was not a previously determined inquiry objective, the resistance to change that initially emerged at the end of Cycle One stimulated participants' curiosity concerning the organisation's readiness for change. For example, from core research group discussion and drawing from organisational change literature concerning resistance to change (Keen, 1981; Folger and Skarlicki, 1999; Self and Schraeder, 2009; Appelbaum et al.

2015a, 2015b), participants explored how to overcome the resistance that was present at that time and, where possible, how to prevent any emerging resistance as the inquiry unfolded.

According to Kristen (2000), attitudinal and behavioural elements of resistance may emerge in the process of organisational change, while Coetsee (1999) suggests that components of resistance can include a lack of interest, negative attitudes, and overtly oppositional views of the change and workplace strikes. In this inquiry, participants explored the possible causes of the resistance, with a view to proposing solutions for overcoming both the resistance and the contextual problems it was creating. A summary of potential causes of resistance gleaned from the literature includes:

- *Psychological:* Val and Fuentes (2003) highlight employees' negative perception of the change, preference for remaining with the status quo, and fear of change and/or failure as contributing factors underlying resistance.
- *Employees concern for the organisation:* Dubrin and Ireland (1993) indicate that employees can find fault or deficits with the planned change, where components of the change may conflict with culturally ingrained practices.
- *Employee's expertise:* the fear of eroding or replacing employees' skills, knowledge and expertise were causal factors underlying resistance (Laurence, 1986).
- *Materialistic:* this may be financial losses, perceived or actual demotion of tasks, roles or positions or fear of job loss.

  Dent and Goldberg (1999)

The *observation phase* in each Cycle of this inquiry made reference to potential - subjective causes of resistance that occurred during the inquiry process. While the inquiry approach and scope did not enable further exploration of those subjective influences, it seems that elements such causes of resistance are consistent with the literature. For example, some participants (nurse and occupational therapist) expressed *psychological* difficulties they had in working with aspects of addiction relative to their knowledge, roles and experience. From the multi-disciplinary, team-based approach to dual diagnosis assessment and treatment, participants generally responded to the phase of assessment and treatment as required, though some felt their *expertise* was compromised or lacking in accordance to expectations linked with the occurring change. Furthermore, some participants who seemed deeply ingrained in certain

ideologies appeared to have *concerns for the organisation* or culture of the organisational departments in the context of the change taking place.

Findings from the inquiry, and indeed some of the emergent percepts, were informed by varying levels and demonstrations of resistance. The learning process over the three Cycles of inquiry included the innate experience of resistance within formal groups and informal resistance from peripheral participants across the organisation. While change was perceived as good or bad, welcome or unwelcome, nevertheless when the challenge emerged in this context, rather than avoiding or ignoring it, the core research group decided to work with it. As discussed, that decision coincided with the emergence of the percept, *Is the organisation ready for change?* The collaborative exploration of what informed that percept enabled an impetus which focused on creating organisational readiness for change, rather than trying to struggle with the resistance to it. In order to create such readiness, the following five elements posited by Armenakis et al. (1999) were employed:

1. *The gap between the current level of change/engagement and the one desired was identified.*
2. *Deciding that the proposed changes were the correct solution to bridging the gap between the current and ideal state.*
3. *Develop efficacy and confidence in all participants to collectively bring about the desired change.*
4. *Involve key formal and informal organisational supports to begin to adopt the change.*
5. *To understand that answering the 'what's in it for me' question is important for each stakeholder concerning the value of the outcome of the proposed change.*

   Armenakis et al. (1999)

The implementation of these key elements occurred through formal meetings and informal communication/interactions between participants, as demonstrated in each Cycle of inquiry. Evidence of this was the participation of all hierarchical tiers in the planning, development and implementation of various aspects of the new service, a solid signifier of the organisation's readiness for sustainable change. This collective participation of stakeholders enabled the resistance to be processed as it emerged and demonstrated that the organisational change was justified and appropriate. The implementation process also demonstrated that the organisation was capable of change (Gist and Mitchell, 1992), with the outcomes of this

change benefiting all participants. As the results of the change became increasingly embedded over each Cycle, the chances of resistance inhibiting the change was significantly minimised.

In this, the organisation's response to dual diagnosis transformed over the course of the inquiry, through the development of and access to appropriate services, and by the integrated healthcare practitioner response to those experiencing complex needs. The inquiry did not aim to measure such change, though as described in the evaluation (pp.248-256), the change was incrementally demonstrated in the findings that emerged from each Cycle of inquiry. This transformation has implications for future practice, particularly as the change process included both those experiencing complex needs and those working with them.

As discussed, while the methodology enabled such collaboration, participation inevitably fluctuated though was maintained throughout the transformation process. From my collective experience in related services, service-user participation in service development is promoted and adopted by some, but remains an unrealised ideal in others. In the context of this change process, however, the transformation that has occurred demonstrated that such authentic and sustained collaboration is possible when a collective willingness to do so is mobilised.

Lewin's (1946) theoretical model for organisational change was adapted to this context with the aim of developing a new dual diagnosis service. The particular characteristics and flexibility of PAR's worldview (Reason and Bradbury, 2008) were suited to the environment of this inquiry, where participants came from diverse backgrounds within and outside the organisation's hierarchical structure. While multiple theoretical perspectives can be selected to influence participatory action research (Borda, 2001; Kemmis, 2001; Borda, 2006; Kemmis, 2006), the guiding theoretical perspective chosen for this inquiry was pragmatism (Methodology chapter p.82) because of its affinity with PAR and the flexibility required within a complex environment. Where organisational members and service-users are continually shifting positions, roles and levels of engagement with the organisation, as a philosophical approach, pragmatism responds to the *situation in view*, whatever the context.

Underpinned by pragmatism, PAR's methodological approach enabled the adoption of particular methods of inquiry to blend with the dynamics of the research context. Figure 19 illustrates those organisational dynamics, service developments and the perceptual framework that emerged from each Cycle (p.263), where the adopted methods mobilised the cyclical nature of the research process, influencing the inquiry outcomes. As illustrated in the Cycle

chapters, each Cycle had a *reflective, planning, action* and *observation* phase, which suited the complexities inherent in this research. From this PAR approach, both organisational change and knowledge were created in the process, while dissemination of findings were already in place.

PAR as an organisational development tool

The increasing utilisation of PAR is evident in developing healthcare services (Burgess, 2006; Watters and Comeau, 2010; MacFarlane et al. 2014; Taylor et al. 2015; Padilha et al. 2016), as it provides a high level of research flexibility in its application of appropriate methods to wide-ranging contexts. PAR's emphasis on partnership and collaboration, the development and testing of new knowledge and theory, and its evaluative components equally render its appropriateness to fulfilling related policy objectives. Both the Methodology and Methods chapters have discussed various applications of PAR, including that of organisational problem-solving and service development initiatives. Its application in this particular context was that of a service development, though the process equally demonstrated its alignment with organisational development (Senge et al. 1993; Kotter, 1995, 1996; Senge et al. 1999). The rationale for the inquiry included the need for an integrated service that did not previously exist, where its aim and objectives were designed to develop a new service within the existing organisation.

The application of Lewin's (1948) cyclical model of *Reflect, Plan, Act, and Observe* was re-defined in this particular setting, where PAR's mechanism generated knowledge about the social system whilst simultaneously changing it. Together with the introduction and testing of a practical theory, each element of each inquiry Cycle enabled the evolution of all context-specific stages of the unfolding service to emerge. Methodologically, when stakeholders disengaged at the end of Cycle One, the methodology's *observation* and *reflection* processes enabled a re-engagement *action* to be planned for, which consequently increased engagement in Cycle Two. Likewise, where the data collection method of focus groups seemed appropriate and were originally planned for, participants ultimately favoured the method of semi-structured interviews, which PAR's flexibility enabled. The methodology further enabled dialogue generation (Gustavsen, 2001) between multiple stakeholders across the organisation's hierarchical system, which helped maintain engagement in core research group processes while implementing the service's operational policy in practice. Cycle One

demonstrated the collaboration of service-users with representatives from all relevant disciplines employed by the organisation in a process of change that benefited all stakeholders. While utilising existing resources, participants crossed organisational boundaries to collectively develop and access services that were previously unavailable or inaccessible. As the methodology facilitated such organisational developments, the inquiry process in Cycle Two equally highlighted their unsustainability in the absence of additional funding.

However, as particular aspects of the service were embedded throughout all Cycles of inquiry and which continued with the *ends in view* in Cycle Three, the application of PAR in this context enabled all hierarchical positions to participate in the service development. As many organisational development objectives may fall short in their implementation (Choi and Behling, 1997; Gilmore et al. 1997), PAR's approach has engaged the necessary levels of the organisation to realise the inquiry's aim and objectives. Furthermore, PAR has worked with and overcome resistance both within the core research group itself and with stakeholders across the hierarchy. With this approach, PAR has overcome resistance to organisational change by creating an environment of readiness to change as demonstrated over the Cycles of inquiry and the emergent theoretical development. Thus the application of PAR in this context has been an effective organisational instrument which may inform other service development objectives.

Quality in PAR

'*A key test for any researcher is to produce valid findings*' (Hope and Waterman, 2002, p.120). The Methodology chapter (pp.65-69) explores positivist and naturalistic approaches to research that are generally judged on validity criteria (Guba and Lincoln, 1994), while the participatory action research approach to inquiry ought to be evaluated from within the paradigm within which it resides (Anderson and Herr, 1999; Reason and Bradbury, 2001; Coghlan and Brannick, 2010; Helskog, 2014). In this, Reason (2006) highlights:

> '*the movement in qualitative research away from validity as policing and legitimation towards a concern for validity as asking questions, stimulating dialogue and making us think about what our research practices are grounded in*' (p.191).

Though validity in the realm of action research contrasts that of quantitative and qualitative research, for strategic objectives, including dissemination and dissertation evaluations, the

terminology of 'validity' will be maintained, as outlined by the following criteria (Herr and Anderson, 2015, pp.66-70).

Goals of Action Research	***Quality/Validity Criteria***
1. *Generation of knowledge*	*Dialogic and process validity*
2. *Achieving action-oriented outcomes*	*Outcome validity*
3. *Education of all participants*	*Catalytic validity*
4. *Results relevant to local context*	*Democratic validity*
5. *Sound and appropriate research methodology*	*Process validity*

Herr and Anderson (2015, p.67)

Dialogic validity refers to the research process being peer-reviewed by other action researchers in academic journals, as in Cycle One (Connolly et al. 2015). *Process validity* questions to what extent the findings emerged from a series of reflective Cycles, re-examining contextual factors associated with the evolving process. The three Cycles of this inquiry illustrated a reflective phase, reflecting the authenticity of the evidence that evolved from each Cycle, which was evaluated further.

Outcome validity refers to the extent to which action occurred over the research process. This was demonstrated throughout each Cycle, though more specifically in each action and observation phase within the Cycles. The aspects of the service that were embedded incrementally from Cycle One through to Cycle Three demonstrated what Jacobson (1998) describes as the integrity of the research process, including '*the quality of the action that took place, and the quality of the data on which the action was based*' (p.130). *Catalytic validity* according to Lather (1986) refers to '*the degree to which the research process reorients, focuses, and energises participants toward knowing reality in order to transform it*' (p.272). In this, inquiry participants engaged in a process where one's subjective view of reality or the status quo of the organisation, highlighted both the challenge and the transformational potential of PAR methodology. Findings from each Cycle demonstrated how participants (including service-users and employees) collaborated effectively in the inquiry process, the extent to which such *democratic validity* occurred was indeed a particular strength of the inquiry.

In this regard, the *intersubjectivity* (Habermas, 2003a; Kemmis, 2008) or the inter-relational dynamics that occurred between participants in the inquiry, created a process from which a way of generating knowledge and co-constructing truth emerged. In this, PAR, acting as a transforming agent, enabled the change actions to take place, whilst stimulating new ways of doing - in terms of planning and implementing a contemporary dual diagnosis service. The percepts arising from the inter-relational dynamics within this methodological process, ultimately co-constructed a perceptual framework and a new way of knowing in this particular context of service development. This co-constructed way of knowing directly correlates with Habermas's (1976) idea of social validity, where *understanding* happens when dialogue is used as a means to arrive at collaborative agreement on what is deemed as valid. In order to validate any research claims made, Habermas posits that the four criteria of *comprehensibility, truth, rightness and authenticity* ought to be present (pp.2-3). Considering these social validity criteria, the three cycles of this research inquiry have illustrated how the research claims made were validated through collective consensus, and can therefore be upheld.

While *validity* (per se) may be more aligned with positivist research, *credibility* with naturalistic inquiry, and *skilfulness* more consistent with action research (Brooks and Watkins, 1994), as participant and author, my interpretation of this inquiry process and related perspectives has inevitably influenced the articulation of this dissertation. Likewise, a reader of such will make judgements based on myriad subjective influences that impact one's interpretation. From the modernist perspective of objectivity and rationality, for example, such interpretations that may lack human consciousness or historical influences may limit judgements to one absolute, of being either true or false (Warf, 1995). On the other hand, the post-modernist perspective will likely acknowledge reality as being more complex, allowing for multiple voices, narratives and perspectives, though nonetheless may judge this account as being insufficiently justified (Routledge et al. 1991). However, guided by the philosophical and theoretical worldview of PAR and pragmatism, I have made a validity claim based on my interpretation that the *situation in view* as it stands provides a significant warranted assertion. What may strengthen my claim is the support of my co-participants, though these are equally reliant on the reader's subjective interpretations. Whatever the perspective, yardstick or lens adopted with which to measure or judge the account of this inquiry, the process in itself has demonstrated that all can co-exist. Where modernist, post-modernist, positivist, post-

positivist, and formal and informal perspectives can appear as being in competition, all elements, according to the worldview of PAR can contribute to completing the whole.

Limitations

The inquiry was limited to the context and time within which it occurred, though, as discussed, what may be interpreted as limitations by one paradigm may not be judged as such by another. While the research focused on an identified aim and objectives, the inquiry demonstrated that implementing change is not merely an event but a multi-faceted process.

The time constraint of the inquiry may have prohibited the potential of integration that this service development has with other dual diagnosis service developments locally and nationwide. In this, the knowledge generated from this organisational development process may inform other dual diagnosis service developments. However, as discussed, the integration of such services can only benefit service-users and service providers, and there may be scope for this in the future.

Above and beyond co-participation

As a co-participant in the inquiry, it was necessary for me to analyse and theorise above and beyond the standard employed by a research co-participant in order to meet the requirements of an academic award. The trials and tribulations of such were initially daunting, challenging throughout and simultaneously deeply rewarding. While some distance from the process may be required to clearly articulate this collective experience, what seemed at the beginning to be daunting has become personally transformational. New insights have broadened my imagination, opening up my future with possibilities to continue to explore further, both in personal and participatory ways.

CHAPTER NINE: CONCLUSION

It seems somewhat peculiar to write a concluding section for a PAR process, given its cyclical and iterative nature and that characteristically it has no conclusions. Nevertheless, as this dissertation has been gleaned from the inquiry/service development process, this account has come to a conclusion. The research question was '*To develop a comprehensive, integrated and contemporary recovery oriented model of care for dual diagnosis, within the environment of primary and continuing care in Cork, Ireland*'. Through the Cycles of inquiry, a service has been developed that reflects the aspirations of the research question. While service developments continue, the process has increased understanding of what dual diagnosis constitutes, and what services and supports those experiencing complex needs require. Because of the development of this new dual diagnosis service, how this cohort ought to be comprehensively responded to has been reconfigured. These particular advances in the delivery of a dual diagnosis service have occurred with the utilisation of the organisation's existing resources.

Contribution to knowledge and service development

In this study, PAR has demonstrated efficacy as a transformational agent through a new way of doing, evident in the design, development and implementation of a dual diagnosis service. In this environmental context, the dynamics of the inter-relational process has enabled the co-construction of a perceptual framework and a new way of knowing to emerge. Considering Habermas's (1976) social validity criteria of *comprehensibility, truth, rightness and authenticity*, the three cycles of this inquiry have illustrated how the research claims made were validated by way of collective consensus, and can therefore be upheld.

What this collective process has demonstrated is that when the appropriate methodology is employed, service transformation can be created within the organisation's existing resources. As the inquiry and its evaluation have highlighted the service's unsustainability in the absence of additional resources, its future hangs on a delicate thread. However, as the solid foundation of the existing service continues to derive positive outcomes for multiple stakeholders, where the quality of people's lives have improved because of the choices provided, I am optimistic that the organisation will allocate the resources required to sustain and develop the service further across Cork city and county.

Ends in view

The overall inquiry evaluation process was difficult to contain and to structure; as described above, the core research group became frustrated with the group processes and, I guessed, with the time they had invested in the process, some of them for several years. This was understandable, and although critical discussions had generally become transparent, some frustrations appeared to remain hidden. The evaluation took place in meetings that were planned for and also in ad hoc meetings, as the busyness of the practice setting at that time did not facilitate an orderly management of this, with recurring issues of room availability and participant attendance. One of the issues raised at one evaluation meeting was that of participation of service-users in the core research group. Participants agreed while this fluctuated in the three Cycles, service-users chose to engage for relatively short periods of time, with the input from organisational employees being greater. This stakeholder variation was evident in the core research group forum, and the probable reasons for this were discussed in Cycles One and Two. Participants agreed, however, that service-users actively participated in other pertinent service development contexts, evidence of which was demonstrated by their participation in data collection and often daily engagement with services and activities that had developed over the inquiry. In terms of evaluation, it was agreed that active service-user representation would be important at planning and reflection meetings in Cycle Four.

Regarding my own position in the overall evaluation process, I agreed to collate all the feedback and return it to co-participants, after which we would agree on how the inquiry outcomes would be presented.

The *ends in view* are the reality of a new dual diagnosis service in the HSE environment of mental health and primary care. As Cycle Four approaches, the level of sustainability appears high, as this service response to dual diagnosis functions routinely within the organisation. With the optimism that the organisation will provide the additional resources required, the outlook for those experiencing complex needs in Cork is positive.

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APPENDICES

Appendix (A) Research Operational Guidelines

Participative Action Research involves a process of change that happens over time. This brings many challenges unlike other research such as ongoing informed consent, confidentiality, inclusion, transparency and genuine participation as co-researcher. It also entails collaborative involvement in decisions on how the research progresses. These guidelines attempt to address these challenges and will only do so if they are subscribed to and/or altered as the need is identified.

1. *Involve participants*. Encourage others, who have a stake in the improvement you envisage, to shape the form of the work
2. *Negotiate with those affected.* Not everyone will want to be involved, so take account of responsibilities and wishes of others
3. *Report progress*. Keep work visible and open to suggestions so that unforeseen ramifications are taken into account. All involved must have the opportunity to lodge a protest with you
4. *Obtain explicit authorisation before you observe.*
5. *Negotiate accounts of others points of' view (e.g. on accounts of communication).* Always allow others involved in interviews, meetings, and written exchanges to require amendments which enhance fairness, relevance and accuracy
6. *Negotiate reports for various levels of release.* Different audiences require different levels of reports
7. *Accept responsibility for maintaining confidentiality*
8. *Retain the right to report the work.* Providing that those involved are happy with fairness, transparency, accuracy and relevance of accounts which pertain to them and that those accounts do not unnecessarily expose or embarrass those involved, then accounts should not be subject to veto or sheltered by prohibitions of confidentiality.
9. *Make your principles* of *procedure binding and known*. All those involved in the project must agree to the principles before the work moves forward. Others must be aware of their rights in the process.

Appendix (B) Consent Form

Consent Form:

I _____ (Print name)

do fully and freely consent to participate in a research project entitled:

To develop a comprehensive, integrated and contemporary recovery oriented model of care for dual diagnosis, within the environment of primary and continuing care in Cork, Ireland.

I understand and acknowledge that this research project is designed to improve the response to dual diagnosis.

I understand that interviews I may be involved in will be recorded for later transcribing and John Connolly, researcher, has explained to me that my comments will be confidential and my name will not appear on any follow up reports.

I have been given an information sheet which I have read/has been explained to me, that I understand and can keep for future reference.I understand that I may withdraw my consent at any stage of the research project. I acknowledge the purpose of this research which has been explained to me by John Connolly.

Name (print): _____

Signed:_____

Date: _____

Declaration by investigator/co-researcher

I confirm that I have explained the nature, purpose and process of the research to the participant and that her/his consent has been given freely and voluntarily:

Name (print): _____

Signed:_____

Date: _____

Appendix (C) Recruitment Letter for testimonial interviews

To develop a comprehensive, integrated and contemporary recovery oriented model of care for dual diagnosis, within the environment of primary and continuing care in Cork, Ireland

Request for individual interview participants

As part of this research we are inviting service-users to participate in individual interviews. John Connolly would like to ask individual volunteers their views about the current and developing dual diagnosis service.

For further information please contact John on 087 6486432.

Email: john.connolly@hse.ie

Contact Details:

Togher Community Centre, Togher Road, Cork: 021-4322809

Togher Community Mental Health Services: 021-4322078

Thanking you,

_____

John Connolly.

Appendix (D) Resource Application

A Coordinated Dual Diagnosis Service in Cork

The following summary illustrates how the coordination of mental health and primary care addiction services in recent years has led to the implementation of a working model for dual diagnosis in the HSE's geographical area of Cork South. This overview includes evidence of:

(a) the Dual Diagnosis service team delivering the service (see appendix 1)

(b) the designated methodological process which led to the current Dual Diagnosis service

(c) the applicable Irish Governmental policies which have directed this local development

(d) the HSE's National Service Plan 2016 (specifically highlighting clinical programmes for dual diagnosis)

(e) professional publications authored by participants in this service development, illustrating the evolutionary process of cross-sector/multidisciplinary coordination from 2009 – 2015

(f) the rationale for additional posts now required for sustainability

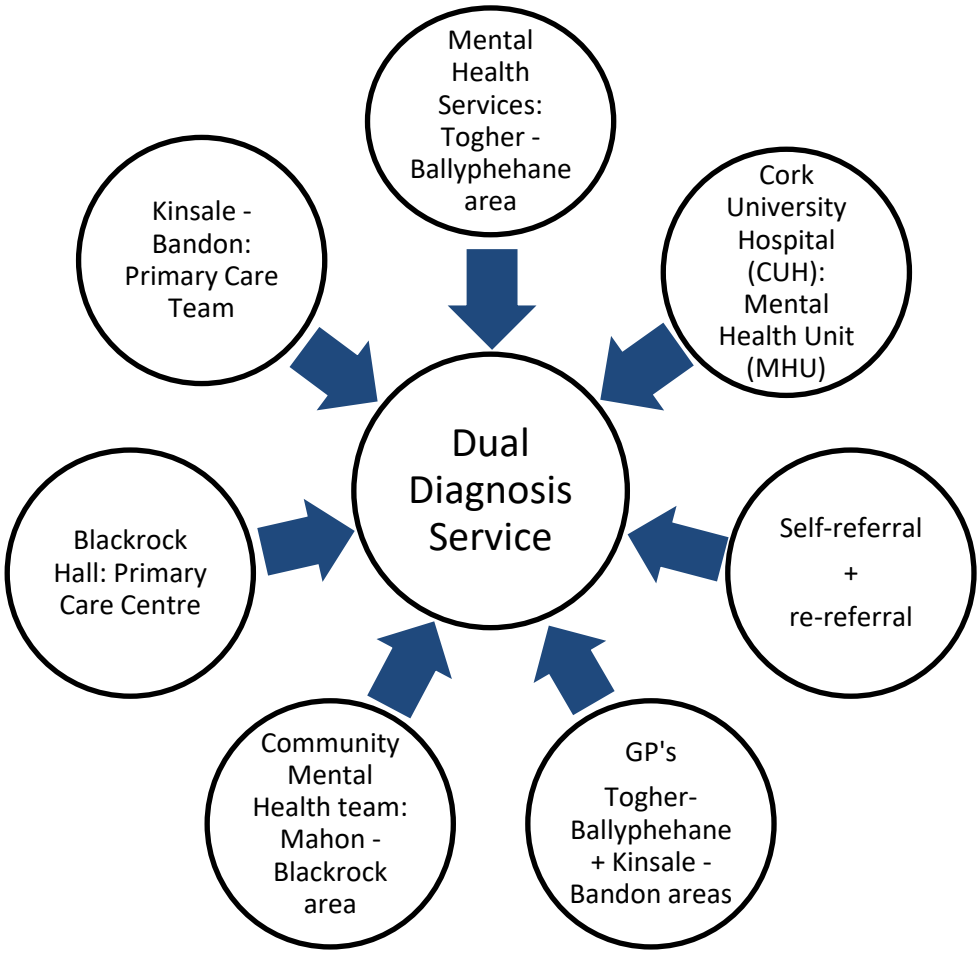
Introduction:

'*The term 'dual diagnosis' is perhaps a misnomer, though it has been adopted internationally to represent a range of clinical representations associated with people who have both mental health and substance misuse disorders and related problems*' (MacGabhann et al, 2004).

The clinical and service provision challenges for dual diagnosis have existed in both mental health and addiction services nationwide for many years. The government commissioned report conducted by MacGabhann et al. (2004) http://www.drugs.ie/resourcesfiles/research/2004/Dual_Diagnosis.pdf has chronicled such challenges. (An updated report has not emerged). The co-location of the mental health and addiction services in the Togher/Ballyphehane area of Cork city in 2009/2010 to a community based setting, created the opportunity for an integrated approach to the management of these co-occurring disorders (dual diagnosis). The coordinated approach to service integration commenced in 2009 and its evolution to date has developed into a service model for dual diagnosis consistent with international best practice in this clinical area. The initial pilot project in Cork emerged informally as like-minded professionals collaborated on responding to this identified gap in service provision. This collaboration included two mental health teams from two local HSE geographical areas; Togher-Ballyphehane and Kinsale-Bandon respectively and the primary care addiction service operating in these areas. As this dual diagnosis service developed, what began as an informal pilot project then became formalised into HSE service provision, with strategic plans to develop this coordinated service across the wider Cork South area. To date, this service development has been established within existing resources.

A complete range of services required by anybody over 18 years of age experiencing complex mental health and addiction (dual diagnosis) needs and requiring a coordinated treatment approach are now accessible in this area of Cork. Typical referral pathways are illustrated in Figure 1. below.

Figure 1. Current referral pathways to the Dual Diagnosis service:



Policy background: an overview

Two Irish government policies signalled the necessity for integrating existing services: the publication of the mental health policy document *A Vision for Change* (Government of Ireland, 2006, p.147; see recommendation no's 15.3 and 15.3.3) highlighted the value of integrating services and tenets of best practice including:

- Multidisciplinary teams should function in an integrated way
- More access to 'talking therapies'
- Services to respond to clients bio-psycho-social needs
- Client participation in service development
- Promotion of the recovery model approach

Following this, the *Transformation Programme 2007-2010* (Health Service Executive, 2006) stated that the reformation of national services should include:

- the collaboration of the mental health services with primary care addiction services
- engagement of staff in facilitating these changes and service developments
- reconfiguration and relocation of staff and resources to community settings

From the addiction arena, *The National Drugs Strategy* (Government of Ireland, 2009) likewise proposed similar objectives including the:

- delivery of comprehensive treatments through multidisciplinary teams
- integration of psychiatric and psychosocial interventions for concurrent disorders
- development of these services in primary care settings

Building on the above policy publications, '*The HSE National Service Plan 2016*' highlights:

'Programme for Government 2016 funding priorities:

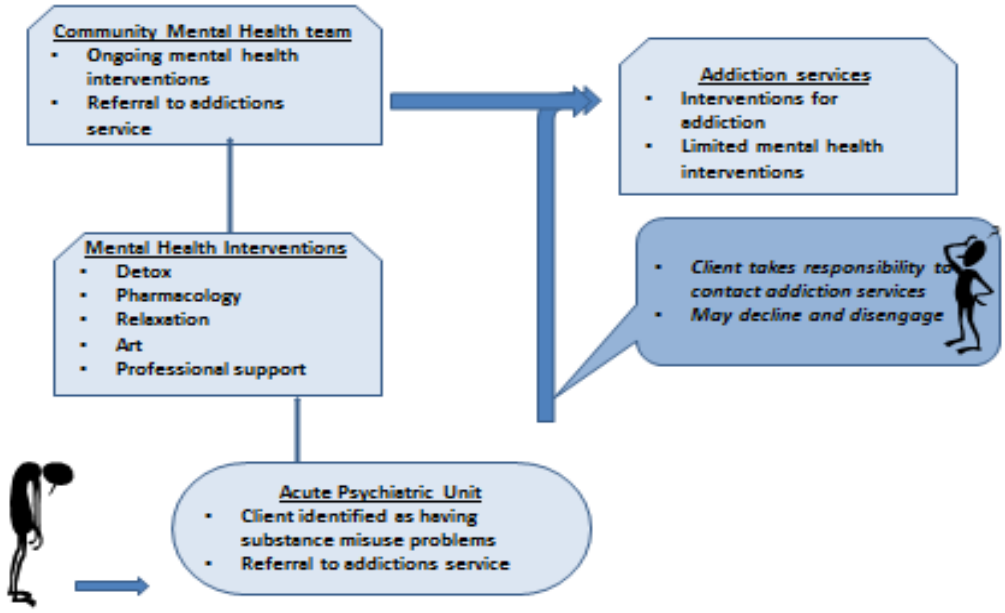
- *Continued investment in clinical programmes, including the development of two new clinical programmes, specifically Attention Deficit Hyperactivity Disorder (ADHD) in adults and children and dual diagnosis of mental health and substance misuse'* (Government of Ireland, 2015).

Considering such proposed *integration of services* as signalled in policies from these various government departments; it is the experience of this dual diagnosis team in Cork 2009 – 2016, that the success of this service development and its delivery is attributed to this particular *coordinated approach*. The approach has proven to be both systemically economical and clinically effective (see Appendix 2) in responding to this complex group that require direct access to a myriad of services and across disciplines.

Prior to the establishment of this integrated service, people with serious mental health diagnoses were not provided for in addiction services, while mental health services were ill equipped to cope with complex addiction issues (MacGabhann et al, 2004, 2010).

Process Map A in Figure 2 below illustrates an example of such challenges encountered by the dual diagnosed service user, prior to this inquiry/service development (see further, Connolly et al, 2015).

Figure 2 - Process Map A: dual diagnosis client experience prior to inquiry



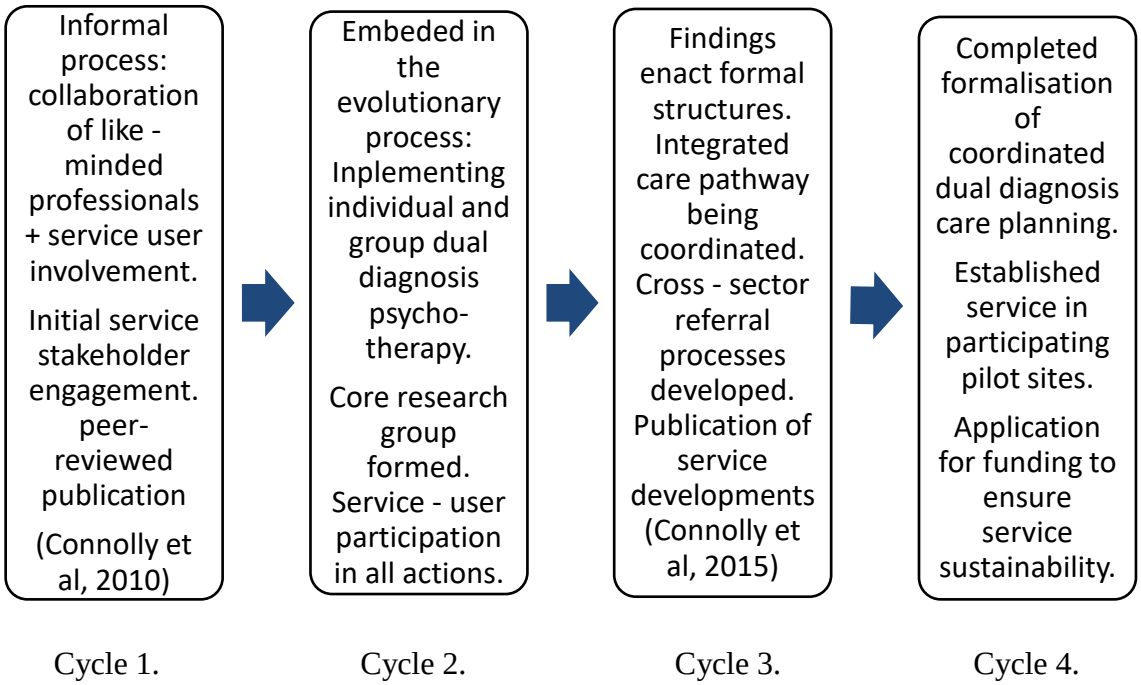
The development of the Dual Diagnosis service:

In the absence of any identified resources or statutory obligation to develop this service, a participatory action research (PAR) methodology was employed to facilitate this development. Service developments within Health Care frequently adopt such action research methodologies (Connolly et al, 2015; Watters and Comeau, 2010; Berg-Powers and Allaman, 2012) as a pragmatic research tool to facilitate integrated working across the primary care and mental health divisions. This methodological approach is further aligned with policy objectives of partnership, integration and collaboration as recommended above.

The initial stage (Cycle One) of the service development commenced with a meeting of all personnel interested in developing the service. Once commitment from key personnel was agreed to develop this approach, the interim dual diagnosis coordinator managed a clear pathway to services. For example, service-users attending mental health services in one sector

could now directly access primary care addiction services in another sector, likewise those attending primary care addictions services in one sector could directly access mental health and related services in other sectors. The following illustration Figure 3. below, highlights the service development stages.

Figure 3 - Stages of the service development:

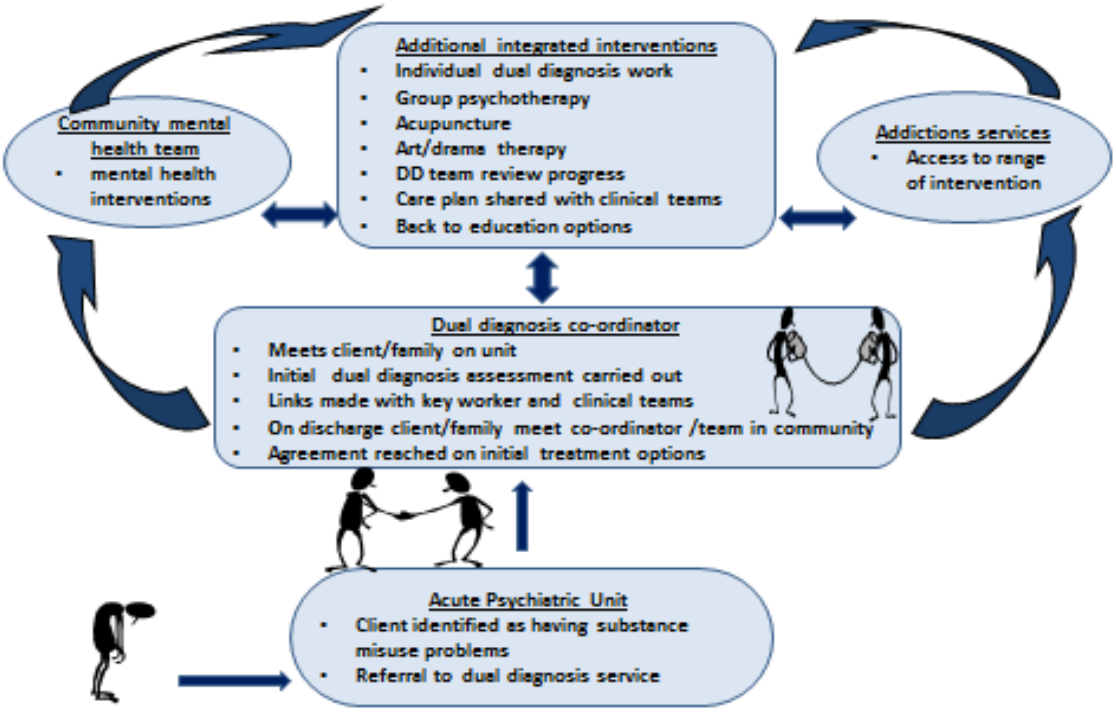


Current Dual Diagnosis Assessment and Treatment services include:

- Screening and Dual Assessment (Comprehensive Mental Health Assessment /Comprehensive Addiction Assessment) – begins at crisis phase/hospitalisation
- Addiction counselling by an interim dual diagnosis coordinator
- Integrated Care Planning (Managed by Coordinator)
- Individual and Group Psychotherapy (facilitated by addiction counsellor, mental health nurse, clinical nurse specialist)
- Relapse Prevention Group
- Individual and Group Acupuncture 4/7
- Individual Art therapy 2/7
- Group Tai Chi sessions
- Mindfulness group sessions 3/7

- Further education options with collaborating local bodies (St. John's College, S.H.E.P. etc.)
- Psycho-education (Topics include: Medication management, Family/carer support, Fellowships overviewed: DRA, AA, and NA.
- Occupational Therapy (OT): Topics include: Return to education/work, Self-Care/Hygiene, Diet/Exercise, Local training/courses available)

Figure 3 - Process Map B below illustrates an example of this coordinated service.



Education and Training Needs:

Education and Training for all practitioners involved in this on-going service development have been clearly identified from its inception (see Connolly et al, 2010, 2015. attached). For example, those professionals having trained in Nursing, Psychiatry and Occupational Therapy report a lack of training and education in the context of addiction. Similarly, those trained in addiction report a related lack of education and training from varying mental health perspectives, particularly concerning psychopharmacology. Though shared learning does

occur through the integration of disciplines providing comprehensive care to this complex group, specific training has been requested across the disciplines to raise competency and confidence in this evidence based practice.

Concluding recommendations:

The dual diagnosis service development illustrated above has been feasible because of this particular coordinated approach to service provision, which has occurred utilising existing resources (see: Connolly et al, 2015, p. 37). For its enactment to date, an interim coordinator helped facilitate this development in the Togher/Ballyphehane and Kinsale/Bandon areas of Cork city. In order to ensure sustainability of this working model and to further develop the service across Cork South (see areas listed below); the following posts are required:

- One full-time dual diagnosis coordinator
- Two dual diagnosis link workers
- Administrative support (0.50 W.T.E.)

These posts would be the only additional costs required to deliver the service comprehensively. Fully implementing and resourcing this particular care pathway will:

(d) Adhere to recommendations made in the *Vision for Change* policy document highlighted above
(e) Fulfil the objectives outlined in the *HSE's Cork and Kerry, CHO Operational Plan, 2016, (pp. 68/69)*, and the *HSE National Service Plan for 2016*
(f) bring this Irish working model in line with international best practice (Bell, 2014; Edwards, 2011) for dual diagnosis service delivery

In addition to maintaining the service in the Togher/Ballyphehane and Bandon/Kinsale areas, with the proposed posts in place the aim is to develop this service in the following geographical areas:

Carragline/Passage West; Douglas/Frankfield/Grange; Blackrock/Mahon; Ballincollig/Bishopstown; Greenmount/The Lough.

Appendix 1

The service development team include:

Geraldine Boyle, Art therapist, Togher/Ballyphehane Mental Health Team

John Connolly, Primary Care Addiction counsellor/PhD candidate – Interim Coordinator

Carmel Cronin, mental health social worker, Togher/Ballyphehane Mental Health Team

Eileen Cronin, Primary Care Development Officer, HSE Cork South

Dr Margaret Anne Duane, Consultant psychiatrist, Togher/Ballyphehane Mental Health Team

Fiona Graham, staff nurse, Togher/Ballyphehane Mental Health Team

Sharon Hannigan, staff nurse, Togher/Ballyphehane Mental Health Team

Dr Eddie Hogan, SHO, Togher/Ballyphehane Mental Health Team

Dr Joe Jordan, NCHD, Togher/Ballyphehane Mental Health Team

Dr Nuril Kamil, SHO, Togher/Ballyphehane Mental Health Team

Dr Grainne Kearney, Clinical psychologist, Togher/Ballyphehane Mental Health Team

Fiona Kelly, staff nurse, Togher/Ballyphehane Mental Health Team

Finbarr Kiely, Community mental health nurse, Togher/Ballyphehane Mental Health Team

Dr Liam MacGabhann, Dublin City University (Methodological supervisor/Project Consultant)

Natalya Mayes, CNM2, Togher/Ballyphehane Mental Health Team

Declan McCarthy, CNM2, Togher/Ballyphehane Mental Health Team

Dr Bernard Murphy, Consultant psychiatrist, Togher/Ballyphehane Mental Health Team

Mary Murray, Clinical Nurse Specialist, Togher/Ballyphehane Mental Health Team

Dr Declan O' Brien, Director, Arbour House treatment centre

Dr Karen O' Connor, Consultant psychiatrist, Blackrock area Home Based Treatment Team

Dr Mary Okafo, Consultant Psychiatrist, Togher/Ballyphehane Mental Health Team

Donal O' Mahoney, CNM2, Bandon/Kinsale Mental Health Team

Catherine O'Shea, mental health social worker, Togher/Ballyphehane Mental Health Team

Ann O' Sullivan, community mental health nurse, Togher/Ballyphehane Mental Health Team

Dr Claire O' Sullivan, Clinical psychologist, Togher/Ballyphehane Mental Health Team

Andrea Pepper, Occupational Therapist, Togher/Ballyphehane Mental Health Team

Philippe Pujad, Acupuncturist/Tai Chi instructor, Arbour House, St. Finbarr's hospital

Dr Lucinda Scott, Consultant psychiatrist, Kinsale/Bandon Mental Health Team

Dr Emmet Stones, Clinical psychologist, Kinsale/Bandon Mental Health Team

Appendix 2. (Anecdotal evidence from service-users and staff)

- *'systemically economical'*: the service has been developed to date utilising existing resources. Evidence published in peer-reviewed publication, Connolly et al (2015).

  '*clinically effective*': (Anecdotal evidence from service-users and staff)

- '*I can deal with both my mental health issues and my drug problem now with the same people which I couldn't do before*' Brian (service user)
- '*I have groups to go to now where I feel comfortable talking about my voice hearing and drug taking, and they understand me, this is great for support*' Michael (service user)
- '*these services are great as they are in my local area and I can talk with people who know about my mental health and addiction problems together, psychiatry is great and I need it but the two things (drink and very bad depression) are the one thing for me, not two*'
  Paula (service user)

- '*the fact that we have this resource within our inter-referral system means we no longer need to refer remotely; super! and must be sustained*' (Consultant Psychiatrist)

- '*having an accessible team dedicated to dual diagnosis means our service-users are comprehensively responded to within our services, where inter-disciplinary communication in this regard makes my work more efficient and clinically effective*' (CNM11- Mental Health Team coordinator)

List of Acronyms:

AA: Alcoholics Anonymous

DRA: Dual Recovery Anonymous

NA: Narcotics Anonymous

S.H.E.P: The Social and Health Education Project

References:

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Appendix (E) Information Sheet

The research project is taking place in the Togher / Ballyphehane and Kinsale / Bandon sectors over the next year. It is part of a PhD enquiry in developing an innovative response to dual diagnosis. An objective is to include all staff and service-users in this inquiry/development.

As there are different phases to this inquiry, participants will be asked again if the wish to be involved. Statements people make will be confidential and compiled typed information will not identify anyone who takes part in the research. Participants will be given an identification number, this alone will only appear on any written report.

There is a summary of the overall research process if one requires further information. If there is anything that anyone doesn't understand about the research at any time please ask this researcher and /or any of the mental health service staff to contact him on your behalf.

For further information please contact John on 087 6486432

Email: john.connolly@hse.ie

Contact Details:

Togher Community Centre, Togher Road, Cork: 021-4322809

Togher Community Mental Health Services: 021-4322078

Appendix (F) Rolling Consent Document

To develop a comprehensive, integrated and contemporary recovery oriented model of care for dual diagnosis, within the environment of primary and continuing care in Cork, Ireland

Over the period Sept 2013 – Aug 2014 there is an ongoing research project in the Togher/Ballyphehane and Bandon/Kinsale HSE sectors to develop a dual diagnosis service in these areas. The type of research is called Participative Action Research, which means that it will attempt to involve service-users and staff as possible in carrying out the research and agreeing how to develop this service.

It is difficult to ensure that everyone is happy with how the process is going and to continually consent to participate. It is hoped that dual diagnosis care will improve as part of the process and that consent is not an issue for this part of the research. Where service-users and staff are being asked their opinion and information about the developing service, it is important that consent is freely given. Also it is important that people have the opportunity not to consent or withdraw previous consent if desired. All of this information will be confidential and no person will be identified in any follow up reports.

It is important that all service-users and staff know that the research is ongoing and have sufficient information to know they have the right to participate or not. There are also a set of `*Research Operational Guidelines*' that should ensure the research is carried out ethically and fairly at all times, without disadvantaging anyone. Please read the attached information sheet before consenting. Where specific stages require further consent this will be discussed with you firstly.

I understand and acknowledge that this research aims to improve the response to dual diagnosis.

I have been given an information sheet which I have read/has been explained to me, that I understand and can keep for future reference.

I understand that I may withdraw my consent at any stage of the research project without it affecting my care. I acknowledge the purpose of this research which has been explained to me by:

_____

Appendix (G) Example of the Data Analysis Process from Cycle One

Codes

Education Referral process Confidentiality Recovery Boundaries Therapies Addiction and mental health Medication diagnosis communication staff training feel heard comfort art therapy mindfulness availability Psychotherapy information and education family members and carers positive feedback feel heard coordinator/ key worker training Feel heard Everyone the same Respect Confidentiality Art therapy Documented information Communication between services/ people involved Evening class Someone to link between services

⇩

Colour Coding

Education information and education family members and carers Addiction and mental health Medication diagnosis

Documented information Communication between services/ people involved communication staff training feel heard comfort Confidentiality

psychotherapy Therapies art therapy mindfulness Art therapy

Evening class availability Recovery feel heard

⇩

Categorisation

Availability of services Communication Education Information Beneficial interventions Group psychotherapy

⇩

Themes

Theme 1 **Service availability** liaison for family and carers clearer referral process staff training coordinator/key worker

Theme 2 **Interventions of care** Beneficial interventions Group psychotherapy

⇩

sub-themes **Theme One:** Service availability Communication Education Information

Theme Two: Beneficial interventions identified Group psychotherapy

Appendix (H) Example of the data analysis process from Cycle Two

Codes

Access structured referral process aware of the kind of staff or kind of staff suitable what is the referral process it's not consistently clear what's the pathway I'm not sure exactly through my GP when I reached a crisis approach them at the same time someone proactive coordinating individual the two are quite intertwined integrated on the team service was expanded I suppose the lack of information I never knew anything

⇩

Colour coding

Access structured referral process aware of the kind of staff or kind of staff suitable what is the referral process it's not consistently clear what's the pathway I'm not sure exactly through my GP when I reached a crisis

approach them at the same time someone proactive coordinating individual the two are quite intertwined integrated on the team service was expanded

I suppose the lack of information I never knew anything

⇩

Categorisation

Identified needs for a structured referral pathway the coordination of integrated care.

Information integration. Service ambivalence and ambiguity.

⇩

Themes

Theme 1 **Identified needs for a structured referral pathway** the coordination of integrated care.

theme 2 **Information** integration. Service ambivalence and ambiguity.

⇩

Sub-themes

Theme One: the coordination of integrated care.

Theme Two: integration. Service ambivalence and ambiguity.

Appendix (I) Example of the data analysis process from Cycle Three

Codes

2011 GP referral 2016 referral to dual diagnosis service treated separately totally different tried to understand I think this made all the difference both sides of my problem being looked at no comparison everything must be looked at this whole dual diagnosis service is super I dunno how I would manage without it the service then is nothing like the service now there's at least one person who makes sure my care is managed met someone from the dual diagnosis team given much more information I got to know them

⇩

Colour coding

2011 GP referral 2016 referral to dual diagnosis service separate services treated separately

expanded tried to understand I think this made all the difference both sides of my problem being looked at no comparison everything must be looked at this whole dual diagnosis service is super I dunno how I would manage without it the service then is nothing like the service now there's at least one person who makes sure my care is managed met someone from the dual diagnosis team given much more information I got to know them

⇩

Categorisation

Experiencing the referral pathway

Experiencing Service Integration

⇩

Themes

<u>Theme 1</u> Experiencing the referral pathway

<u>theme 2</u> Experiencing Service Integration

Appendix (J) Service Operational Policy

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Standard Operational Policy

South Lee Mental Health Service

Dual Diagnosis Service

Author: Dual Diagnosis Working Group

Approved by: (Pending approval)

Date for review:

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1. Purpose of service and operational guidelines

The Dual Diagnosis service is a multidisciplinary team (MDT) of professionals providing innovative assessment and treatment to people with a dual diagnosis. This service operates both at community and hospital level.

For the purpose of this operational policy the term Dual Diagnosis will refer to: problematic use of illicit and/or volatile substances including prescribed drugs or alcohol and other addictions co-existing with episodes of mental ill health, each interacting with the other, effecting the individual in a variety of ways.

The Dual Diagnosis service aims to empower and enable service-users to take an active role in their recovery. The MDT will work collaboratively to provide a holistic, comprehensive, recovery oriented model of care focusing on the psychological, physical, social and occupational needs of each individual.

This policy provides the operational guidelines under which the Dual Diagnosis service currently operates.

2. Values

2.1 Core Values of the Dual Diagnosis service

- We provide services that promote recovery and hope.
- We believe that everyone is an individual with their own beliefs, values, experiences and needs.
- We endeavor to empower everyone to exercise personal choice and responsibility for themselves and their health.
- We aim to deliver care in collaboration with the service-users, carers, statutory and non-statutory organisations in order to provide an integrated service.
- We promote open communication for all.
- We will promote and respect the principle of equality and diversity and deliver practice which is non-discriminatory.
- We will invest in training and development for staff in order to build a skilled and compassionate workforce (see recommendations)

3. Service aims and objectives

3.1 Aims

The primary aim of the Dual Diagnosis service is to deliver an integrated model of care for Dual Diagnosis that will empower and enable service-users to take an active role in their recovery.

3.2 Objectives

The Dual Diagnosis service will:

- Respond to referrals to service, both from community or hospital settings, in a timely manner.

- Ensure that individuals experiencing co-occurring mental health, addiction and substance use difficulties can be seen in a variety of settings.
- Work collaboratively with the service user to reduce their vulnerability to crisis and augment their resilience.
- Adopting a person-centered and recovery oriented approach for service-users and where appropriate with family/cares participation in their plan of care.
- Provide a high standard of individualized care at all times.

4. Access criteria

4.1 Who is the Dual Diagnosis service for?

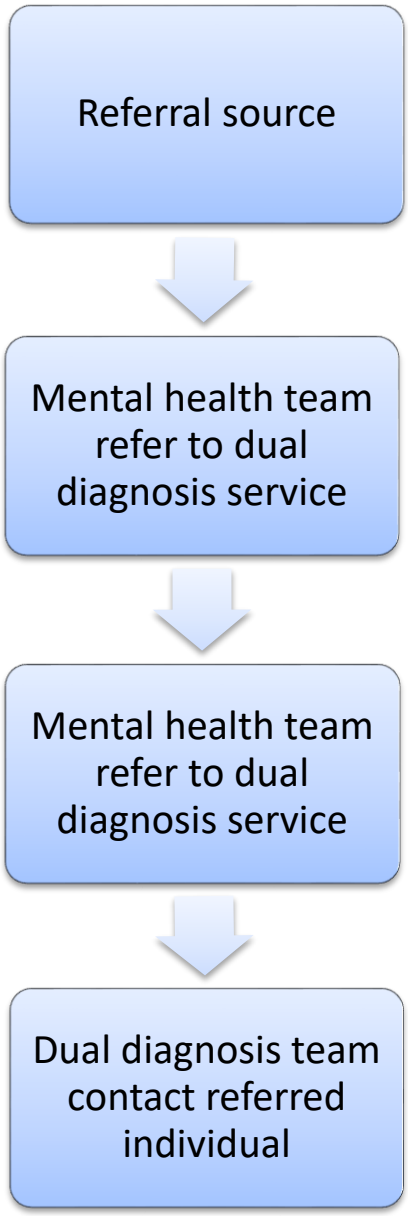
The Dual Diagnosis service is for people aged over 18 years with co-occurring mental health, addiction and substance use difficulties living in the catchment areas of City South West and Bandon / Kinsale in South Lee Mental Health Services and Primary Care Addiction Services, as well as accepting referrals from the Home Based Treatment Team. Due to current limitations of resources the service also provides guidance, advice and signposting for those living in other catchment areas. (see recommendations).

The Dual Diagnosis service incorporates an integrated MDT approach which responds to the specific needs of those experiencing the co-occurrence of mental health and addiction difficulties.

4.2 Referral process

- Currently referrals to the team can **only** be made by members of City South West and Bandon / Kinsale teams in South Lee Mental Health Services and Primary Care Addiction Services, as well as from the Blackrock Hall, Home Based Treatment Team (see appendix 1)
- Service-users who have disengaged from the dual diagnosis service can also re-engage.
- Referrals are made using the MDT referral form (see appendix 2).
- GPs can also refer to the service from the areas listed above. A GP letter will be required (see recommendations).
- The service user must be aware of the referral and consent to be assessed by a member of the Dual Diagnosis service.

4.3 Referral protocol



4.4 Referral suitability/exclusion criteria:

The Dual Diagnosis service will ultimately decide whether the referral is acceptable and appropriate. The dual diagnosis service will keep the referrer informed of the service user's engagement or non-engagement with the service.

5. Assessment and engagement

Assessment will commence at receipt of the referral, and will be an ongoing process throughout the course of engagement with the service.

Participating disciplines involved in the person's care will be kept informed of any changes/ interventions.

- The outcome of the decision to accept the referral will be communicated to the referrer.
- The approach to care aims to be person-centred and recovery oriented.
- Participants of the dual diagnosis service will have access to the full multi disciplinary team across mental health and/or primary care services, as appropriate.
- Referrals can also be made to private clinicians (i.e. psychotherapy).
- The Dual Diagnosis service may utilise standardised assessment tools throughout the process of care (see appendix 3).

6. Features of service:

6.1 Interventions will be multidisciplinary and typically include:

- **Education and support**: provides particular information and support on medication use, side effects etc. – in collaboration with general practice (GP's) if appropriate.
- **Social support coordination:** provides assistance/advice with housing, benefits and community supports.
- **Interventions aimed at increasing resilience** e.g. problem solving, stress management, harm reduction and relapse prevention planning, safety planning, referral to CBT/DBT.
- **Vocational support**: to support engagement with community based activities – education and/or employment
- **Family and/or carer support:** Education and involvement of carers'/family members to facilitate recovery.

6.2 Planning Care

- A focused plan of care will be developed and will include mutually agreed detail relative to the individual's recovery over the course of engagement.
- Discharge planning will be discussed throughout the process.
- Plan of care will be discussed at each MDT meeting when appropriate, or with relevant MDT members outside of meeting times.
- Plan of care will be flexible in response to changing needs.

6.3 Discharge planning

- Discharge will be dependent on the service user's needs and engagement with the service.
- A relapse prevention plan will be developed with the service user prior to discharge and will be shared as appropriate with carers and family.

6.4 In-reaching into Acute Adult Mental Health Unit (AAMHU)

The dual diagnosis service will provide a psycho-education group to the AAMHU. This group will be open to inpatients presenting with a dual diagnosis from all sectors.
The dual diagnosis team will also provide community support (1:1 and / or group) to service-users from identified areas outlined in the operational policy (see recommendations). Referrals can be made on the MDT referral form (see appendix 1).

6.4.1 Discharge from AAMHU

- The dual diagnosis coordinator/link worker will work collaboratively with AAMHU staff during the hospital stay.
- Where possible the coordinator/link worker will attend relevant ward meetings to review the person's progress and/or discharge.
- Planning and implementing requirements for discharge to less restrictive care is a shared responsibility between the AAMHU team and the dual diagnosis team.

6.5 Disengagement from service:

- Contact will be made with the service user/next of kin with the service user's consent.
- If concerns arise regarding the service-users safety, contact will be made with the relevant MDT and the service-users GP.
- A letter may be sent to the service user providing an opportunity to re-engage with the service, which will be copied to the MDT and the GP.

7. Staffing, Roles and Responsibilities

7.1 Staffing

This service is staffed by a multidisciplinary team working in AAMHU and community settings.

7.2 MDT meetings

All new referrals and regular reviews will be discussed at the relevant MDT meeting, ensuring good communication and sharing of relevant information.

7.3 Supervision

- Supervision is available to all personnel in accordance to their respective disciplines

8. Safety and risk management

8.1 Risk management

- Risk assessment is an integral part of care planning in the service (see appendix 4).

8.2 Safeguarding

The HSE policy and procedures in response to any safeguarding issues in relation to children or adults will be adhered to.

8.3 Lone working

The HSE Lone Working Policy will be adhered to.

8.4 Incident reporting

The HSE incident reporting procedure will be adhered to.

8.5 Mobiles phones

All team members will have access to mobile phones.

9. Training and development

9.1 Training

The Team recognizes that continual professional development is a key element of ensuring the delivery of the highest possible quality of service.

9.2 Induction

New staff will receive a period of induction and a copy of the team operational guidelines.

9.3 Confidentiality

HSE confidentiality guidelines will be adhered to.

9.4 Sharing information with partner agencies

Information may need to pass between the Mental Health Services and other participating agencies. In most circumstances the consent of the service user will be sought prior to sharing with other agencies. However, in exceptional circumstances i.e. serious risk to self or others, information may be shared without consent.

10. Quality, Performance monitoring and Service Review

The team continuously audits service provision and outcomes, including feedback from people who use the service and their families/carers. Reflective practice forms part of service development.

10.1 Complaints procedure

The HSE complaints policy will be adhered to.

Appendix 10.1: MDT referral form

Client's name: _____ MRN: _____

Dob:_____

Address: _____

Client's Ph.: _____Client's Mob: _____

Diagnosis: _____

Referred to (name and title of discipline): _____

South Lee Mental Health Services / City South West Sector

Inpatient ☐ Recent discharge ☐ Outpatient ☐

Has client previously worked or is currently working with other team members or external agencies? If so, please state.

Reason for referral:

Is client aware of referral? yes☐ no☐

Medication:

Any additional information

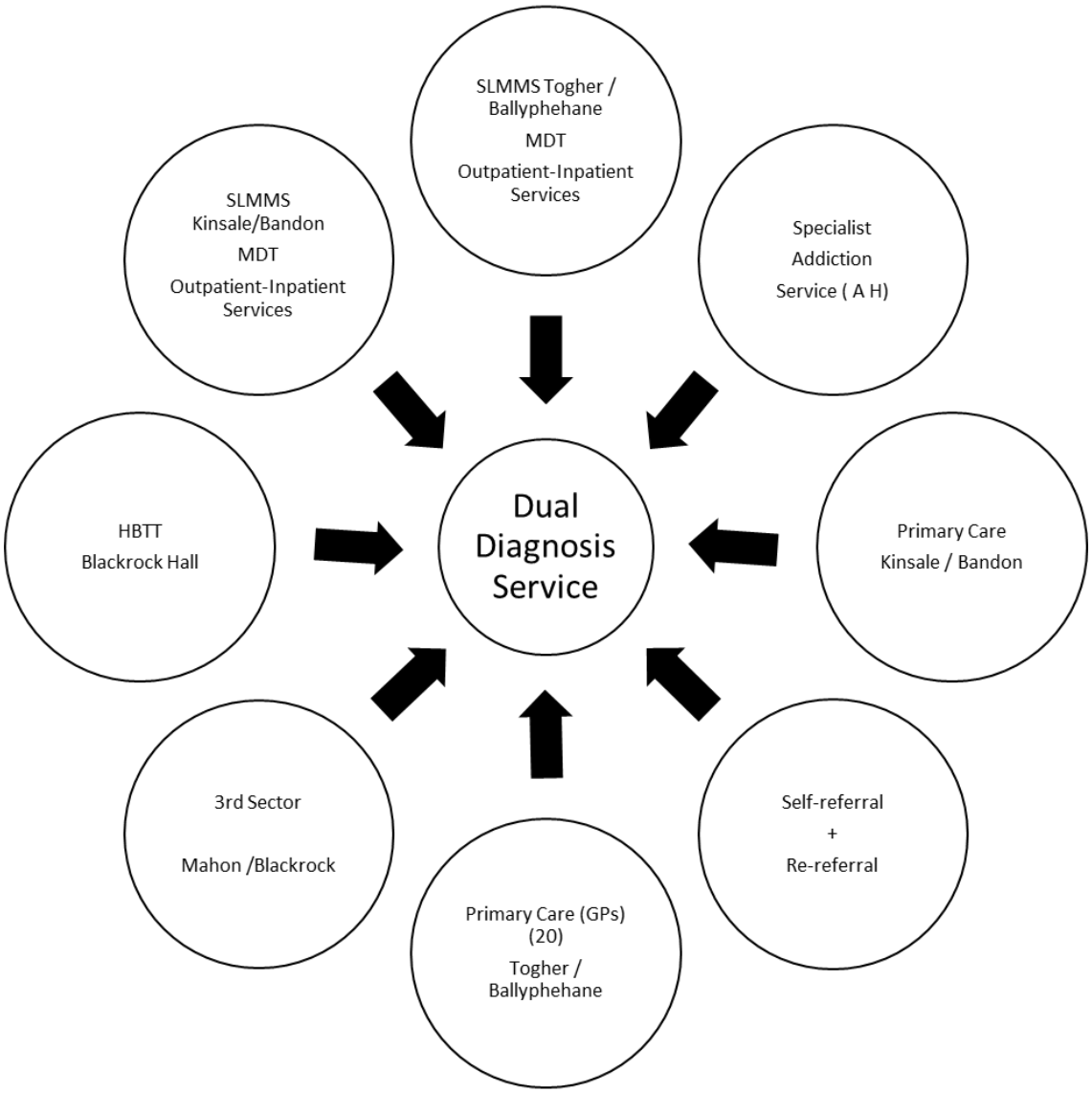
(e.g. presenting problems, history of illness, family background, trauma, safety issues, client's level of insight into diagnosis)

Indicate if copy of detailed letter is attached: yes☐ no☐

Referral received	Contact made (prior to start)	Discharged	Reports written
		Number of sessions	

Appendix 10.2

Current referral sources to the Dual Diagnosis Service:



Appendix 10.3

Recommended tools for use where appropriate

AUDIT

DUDIT

MMSE

BDI

BAI

BPRS

Recommendations:

- (2.1) Practitioners take responsibility to access available training (e.g. SAOR)
- (4.1) & (6.4) Extra resources required – when the service is fully resourced, it is envisaged that referrals will be accepted by the wider areas of Cork city
- (4.2) A full time Dual Diagnosis coordinator is required for sustainability of the current service
- (4.2) Dual Diagnosis link workers are required for sustainability of the current service
- (4.3) MDT referral form to be emailed as an attachment to GP's. Recommended for efficiency and confidentiality purposes that referrals be sent to the Dual Diagnosis team by email, with an option also for standard mail – One email address to be applied for.

Appendix (K) Data Analysis example: Colour Coding and Categorisation

This section examples how initial codes emerged from the three data sources, followed by the formation of categories, which in turn informed the identification of potential themes, which are thereafter illustrated. As a collective process, we continually discussed what was emerging from the three data sources, with findings having both variation and similarities between the three groups.

Data source 1. Core Research Group Codes	**Data source 2. Psychotherapy Group Codes**	**Data source 3. MDT Group Codes**
• Education • Referral Process • Role of disciplines • confidentiality • recovery • boundries • therapies • addiction and mental health • medication • diagnosis • communication • staff training • feel heard • comfort • art therapy • mindfulness • availability • group • psychotherapy • information and education family members/ carers • positive feedback • feel heard • coordinator / key worker • training	• feel heard • everyone the same] • respect • challenged • no judgement • confidentiality • art therapy • documented • information • communication between services or people involved • evening class? • thai chi • education • medication information • addiction treatment • exercise • mindfulness • family involvement • isolation • education diet and exercise • no idea what's available • services should be more available • weekends • evenings • see someone outside the group • someone to link between mental health and addiction • person trained in both	• unclear referral process • limited to 2 sectors • does discharge policy apply • individual therapy • group therapy • art therapy • education • care planning • written communication • link person between services • acupuncture • training • liaison for family and carers • family and individual training • documentation • family involvement • confidentiality

Categories

Referral Process

- **unclear referral process**
- **limited to two sectors**
- **who can refer?**

These codes matched 2 groups

Service development

- **liaison for family and carers**
- **staff training**
- **coordinator / key worker**
- **training**
- **Role of disciplines**
- **someone to link between mental health and addiction**
- **person trained in both**

SERVICE AVAILABILITY

- **services should be more available**
- **weekends**
- **evenings**
- **evening class?**

COMMUNIATION

- **confidentiality**
- **family involvement**
- **communication between services or people involved**
- **care planning**
- **written communication**
-

EDUCATON

- **medication**
- **diagnosis**
- **addiction and mental health**
- **medication**
- **diagnosis**
- **information and education family members/ carers**
- **family and individual**
- **medication information**
- **addiction treatment**

- **art therapy**
- **mindfulness group**
- **psychotherapy**
- **thai chi**
- **acupuncture**
- **individual therapy**
- **group therapy**
- **art therapy**
- **mindfulness**

Matched all 3 groups

- **feel heard**
- **comfort**
- **see someone outside the group**
- **positive feedback**
- **feel heard**
- **feel heard**
- **comfort**
- **recovery**
- **boundaries**
- **feel heard**
- **everyone the same]**
- **respect**
- **challenged**
- **no judgement**

Matched all 3 groups

1. ***Reviewing themes:***

2. ***Searching for themes***

The examples above illustrate how the data was initially categorised and where different codes were identified across the three data sources, from this the analysis process then proceeded to identifying potential themes. In this, many codes were combined which formed over-arching themes, with some codes forming themes of their own. Some of the initial codes went on to form main themes, while others became sub-themes with more being stored as peripheral data, which may be of use at a later stage in this or subsequent cycles.

Appendix (L) MDT Referral Form

Client's name: _____ MRN: _____

Dob:_____

Address: _____

Client's Ph.: _____Client's Mob: _____

Diagnosis: _____

Referred to (name and title of discipline): _____

South Lee Mental Health Services / City South West Sector

Inpatient ☐ Recent discharge ☐ Outpatient ☐

Has client previously worked or is currently working with other team members or external agencies? If so, please state.

Reason for referral:

Is client aware of referral? yes☐ no☐

Medication:

Any additional information

(e.g. presenting problems, history of illness, family background, trauma, safety issues, client's level of insight into diagnosis)

Indicate if copy of detailed letter is attached: yes☐ no☐

Referral received	Contact made (prior to start)	Discharged	Reports written
		Number of sessions	

Appendix (M) Ethical Approval Document

COISTE EITICE UM THAIGHDE CLINICIÚIL

Clinical Research Ethics Committee

Lancaster Hall,

6 Little Hanover Street,

Cork.

Tel: + 353-21-490 1901

Fax: + 353-21-490 1919

University College Cork, Ireland

20th February 2013 Our ref: ECM 4 (v) 12/03/13

Dr Liam MacGabhann

Lecturer

School of Nursing & Human Sciences

Dublin City University

Dublin 9

Re: Developing a comprehensive dual diagnosis (addiction and mental health) model within the environment of primary, community and continuing care (PCCC), by way of Participatory Action Research (PAR).

Dear Dr MacGabhann

Expedited approval will be granted to carry out the above study subject to receipt of the following.

⇨ Clarification regarding Site of Performance: This section of the application form (page 1) is incomplete

The following documents have been approved:

⇨ Signed application form

⇨ Study Protocol dated 18th February 2013

Waiver of consent has been granted.

We note that the co-investigator involved in this study will be:

⇨ John Connolly

Yours sincerely

Professor Michael Molloy, Chairman

Clinical Research Ethics Committee of the Cork Teaching Hospitals

Appendix (N) Personal/Professional Development

2013

International Dual Diagnosis Conference Presentation, Barcelona, Spain. October 23-27

Methodology Supervisory Meeting, DCU. November 12

Dual Diagnosis Lecture Presentation, College of Commerce, Cork December 3

(NUIG, Diploma Addiction Studies Course)

2014

Methodology Supervisory Meeting, DCU February 19

Completed Research Ethics Module, DCU March 7, 28 and April 17

Qualitative Research Methods Summer School, DCU May 8-9

CRSI Conference Presentation, UCC May 20

PAR Methodology Course, Fonty's University. The Netherlands. June 2-6

HSE Primary Care Management Meeting re Resource Application, Cork July 18

HSE Management Review Meeting on Inquiry July 24

PAR Doctoral Student Peer Group Meeting, UCC September 20

Methodology Supervisory Meeting, DCU October 15

Dual Diagnosis Lecture Presentation, MSc. School of Nursing, UCC December 2

2015

Department of Social Inclusion Meeting re Resource Application, Cork January 7

PAR Doctoral Student Peer Group Meeting, UCC January 18

Dual Diagnosis Lecture Presentation, College of Commerce, Cork February 19

(NUIG, Diploma Addiction Studies Course)

Methodology Supervisory Meeting, DCU	March 10
PAR Doctoral Student Peer Group Meeting, UCC	April 17
Qualitative Research Methods Summer School, DCU	May 5-6
CRSI Conference Presentation, UCC	June 2
PAR Doctoral Student Peer Group Meeting, UCC	July 15
HSE Management Review Meeting on Inquiry, Cork	July 20
PAR Doctoral Student Peer Group Meeting, UCC	September 14
Methodology Supervisory Meeting, DCU	October 17
Methodology Supervisory Meeting, Cork	November 24
Dual Diagnosis Lecture Presentation, College of Commerce, Cork (NUIG, Diploma Addiction Studies Course)	December 6
Dual Diagnosis Lecture Presentation, MSc. School of Nursing, UCC	December 12

2016

PAR Doctoral Peer Group Meeting, UCC	January 10
Dual Diagnosis Lecture Presentation, School of Nursing, UCC	February 16
Methodology Supervisory Meeting, DCU	April 9
Qualitative Research Methods Summer School, DCU	May 10-11
CRSI Conference Presentation, UCC	June 6
PAR Doctoral Peer Group Meeting, UCC	June 20
HSE Management Review Meeting on Inquiry, Cork	July 12
PAR Doctoral Peer Group Meeting, UCC	September 19
Dual Diagnosis Lecture Presentation, MSc. School of Nursing	October 25
Methodology Supervisory Meeting, Cork	November 9
Dual Diagnosis Lecture Presentation, College of Commerce, Cork	December 4

2017

PAR Doctoral Peer Group Meeting, UCC	January 12
Methodology Supervisory Meeting, DCU	January 20
Dual Diagnosis Lecture Presentation, School of Nursing, UCC	February 16
Methodology Supervisory Meeting, DCU	February 28
PAR Doctoral Peer Group Meeting, UCC	March 24
Dual Diagnosis Lecture Presentation, School of Nursing, UCC	April 19
Methodology Supervisory Meeting, Cork	April 26
Methodology Supervisory Meeting, DCU	May 3
Methodology Supervisory Meeting, DCU	June 14
Protected time for Final Dissertation Write-up	May 15-29, June 5-26

Appendix (O) Inquiry Related Publication 1. Connolly et al. (2010)

Appendix (P) Inquiry Related Publication 2. Connolly et al. (2015)