Awakening the Transformative

An Autoethnographic Exploration of Implementing Learning and Development in the Irish Mental Health World

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Declaration

The opinions and views expressed in this context statement are mine alone and do not represent the views of Middlesex University.

Dedication

To you Anne Marie*, my Annie*: my wonderful darling wife, life partner, mother of our two boys: you are my heart and my soul. You have inspired me every second of every day since the moment we met. Little did I know when you stormed into my life back in '89 that things would never be the same, could never be the same: the universe had sent a soul mate, someone who made me want to be better, to do better, every single day: someone who constantly evokes and calls forth the very best in me. I have had the great privilege of sharing the highs and the lows for more than half my life with you. In every step we stand strong, we stand together, and we never give up. The long and arduous journey through your illness only copper-fastens my love, respect and awe for the person that you are: strong and resilient, yet gentle, kind, caring, compassionate, loving and nurturing in every fibre of your being. You are my rock and my foundation, you are my life.

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Thank you for your guidance and support on this doctoral journey. All of our wise conversations have helped me remain true to the spirit of critical autoethnography. You have always invited me to my reflexive edge. Each time I have been prepared to settle for the 'good enough' work, you have invited me to consider how I might go just a little further, deeper and beyond.

Betsy Thom

Thank you for your expert guidance on the context and stance of this work. You have worn your expertise like an invisible cloak, gently guiding me towards completing a piece of work that is both grounded in and informative for the world from which the public works emerge. You have reassured me when self-doubt crept in and pushed me to dig deeper when more was required.

Ruth, Paul and All

To Paul and Ruth, my co-authors for SAOR, and to Brendan and all those who have journeyed with me in the development and implementation of these works. This has been a remarkable fifteen years in our professional lives. I am certain that together we have done some good within our world of practice.

My Boys

To my sons Dylan and Adam: Thank you for your patience at the times when I was hived away in my office writing yet another thesis. Thank you for being just the way you are, two fine upstanding young men who I am tremendously proud of.

Mam

To Mam, Susie O'Shea: In the sixteen years since your passing I have come to realise that it was you who first taught me about person-centeredness and embracing the transformative. You simply lived your life and allowed me to learn from it -*agus go n-éirí an bóthar leat*.

Abstract

The purpose of this context statement is to critically appraise the contribution of previously published public works to my field of professional practice within the mental health world. Critical autoethnography is the method of choice for evaluating the contribution of selected learning and development initiatives which are concerned with changing professional practice. My relationship with the public works is made explicit through an exploration of my personal, professional and socio-cultural roots, the foundations upon which the works were forged, fashioned and came to life. In turn, the public works are presented against the socio-cultural and professional worlds from which they emerged, including the policy, professional, and economic milieu which provided the background for their genesis and implementation.

The context statement, incorporating findings from the autoethnographic analysis and synthesis, is presented in the form of a metaphor of one day (24 hours) of journeying with the public works, and it seeks to immerse the reader in both the analytic processes and synthetic interpretations. The autoethnographic process is captured in the form of selected journal entries and reflections.

Key learning arising from this analysis relates to engaging with the policy context, highlighting practical considerations of implementation, maintaining contextual awareness, teaching for transformation, contributing to evidence, valuing person centeredness and collaboration, acknowledging organisational issues, developing a particular leadership style, and being aware of battle weariness within the public service domain. This learning is further subjected to the eye of critical autoethnography, bringing to the surface deeper insights and awarenesses that include processes of change and transformation: 'the way we do things', the imposter phenomenon, personal tensions, 'command and control' dynamics, and 'covering our asses'. Emerging from this reflective process, key signposts for future works are identified. They relate to creating practice-based evidence, project management processes, and questioning our understandings of transformative learning.

Developing and implementing public works in the Irish mental health world demonstrates that, for such works to have truly transformative potential, we must move from the mundane and the banal to our reflexive edge and beyond. We must step out of our comfort zones and ask ourselves the difficult questions, the questions that wake us up at night, the questions that transform our understanding of ourselves and the personal and professional worlds that we inhabit. We must look beneath and beyond; we must celebrate the wonder and contemporaneously 'embrace the underbelly'; we must expose our broken models and awaken the transformative in ourselves and others.

As well as making a significant contribution to my own learning, this statement captures the contribution of the works and provides a clear methodological path for colleagues undertaking similar initiatives in the future.

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Glossary of Terms

- **AA - Alcoholics Anonymous:** international self help group for people who share a desire to stop drinking
- **ARI - Advancing Recovery in Ireland:** Irish Health Service national initiative, aimed at bringing about the organisational and cultural change in mental health services, which is necessary to support services in becoming more recovery orientated.
- **ASAP - Alcohol and Substance Misuse Awareness Programme:** developed by the Gaelic Athletic Association (GAA), Ireland's largest sporting and cultural organisation to promote healthy use of alcohol.
- **CBT- Cognitive Behavioural Therapy:** A structured evidence-based therapy utilised within the mental health world.
- **Community Healthcare Organisation:** Organisational structure for coordinating community health services in Ireland.
- **GAA - Gaelic Athletic Association:** Ireland's largest sporting and cultural organisation.
- **Health Board:** Organisational structure of health services in Ireland until 2005 (replaced by the HSE - Health Service Executive).
- **HSE- Health Service Executive:** Irelands National Health Service (Akin to NHS in UK).

- **HSELand:** HSE National E learning platform
- **H&SOP - Health and Social Care Professional:** Term used to distinguish the majority of non-medical, non-nursing professionals in Ireland (e.g. social workers, occupational therapists).
- **IAPT – Increasing Access to Psychological Therapies:** Initiative of UK Government designed to improve access to psychological therapies for depression and anxiety disorders.
- **MI – Motivational interviewing:** A model of brief counselling designed to support people in making lifestyle and behaviour changes (widely used in substance misuse services)
- **NATP - National Addiction Training Programme:** National initiative within the HSE that leads substance misuse related training.
- **ONMSD - Office of Nursing and Midwifery Services Director:** National office for nursing and midwifery planning and development within the HSE.
- **OST - Opioid Substitution Treatment (OST):** guidelines developed by the Health Service Executive (HSE) in Ireland for the treatment of people presenting with opiate dependence.
- **RANP - Registered Advanced Nurse Practitioner:** Nurse trained to high level with brief to work autonomously and at an advanced level of clinical care provision.
- **RCNME - Regional Centres for Nursing and Midwifery Education:** centres designated by the Health Service Executive (HSE) throughout Ireland with responsibility for continuing nurse and midwife education.
- **RDATF - Regional Drug and Alcohol Taskforce:** Organisational structure which supports the development and delivery of alcohol and drug services at community level in Ireland.
- **SAOR** – Saor is the Irish word for free. The acronym is used here to delineate the four key steps of brief intervention for substance related problems; **S** – Support, **A** = Ask and Assess, **O** = Offer Assistance and **R** = Refer.
- **SBI:** Screening and Brief Intervention for problem alcohol and drug use.

- **SPIRIT - Structured Psychosocial InteRventions in Teams:** Course that trains practitioners in the use of CBT self-help workbooks.

Chapter 1: Pre-Dawn

No problem can be solved from the same level of consciousness that created it.

(Einstein, cited in Weld, 2012, p.28)

An Early Start

4 AM: I sit here in the darkness of my small home office with this context statement, the express purpose of which is to critically appraise the contribution of previously published public works within my field of professional practice. In the statement, a total of thirteen artefacts are presented for consideration. Detailed consideration is given to the SAOR model (Artefacts 1 - 4) and three mental health learning initiatives, including CBT (Artefacts 5 - 8), Clinical Supervision (Artefacts 9 – 11), and Recovery College South East (Artefacts 12 – 13). These artefacts form part of a larger body of work which is listed as 'Other Works' (see Appendix I for further details). In presenting this work, I intend to make a case for the consideration of these initiatives in part-fulfilment of the Doctor of Professional Studies (Public Works) at Middlesex University. This is it: this is the moment, the final edit, and the final cut! This doctoral journey has been fifteen years in the making, starting with the commencement of the first public offering (SAOR model) back in October 2003. This latter year, while I was registered on the programme, has marked the final push to capture the unique contribution and harvest consequent learning. I invite you now to journey with me through one day of reflection on this day, Sunday 25th November 2018. Let us imagine ourselves, author and reader, journeying together through the context statement in twenty-four hours. Another early start, the pre-dawn where I hammer out words in the hope that at least some may hit the spot, reach a standard, and bring this year of personal and professional wrestling to a worthy conclusion.

I invite you to understand this journey of personal and professional development as I simultaneously make sense of it myself, re-engage with the evolutionary journey of the works, and in the words of (Roberts, 2014), "reflect on particular moments and relational dilemmas that informed my choices" (p. 48). The statement herein is more about critically reflecting upon the works and subsequent learning (personal, professional, socio-cultural and political) than it is about giving a blow-by-blow account

of the journey so far. Critical autoethnography is the method of choice for this reflective journey. Like Robin Boylorn and Mark Orbe, I also hope “to consider how a critical lens can assist in telling [...] stories in the context of [my] broader culture” (Boylorn and Orbre, 2014, p. 17). In line with the words of Albert Einstein, it is necessary to raise my thinking to a new level of consciousness in order to critically reflect upon the works and my reciprocal relationship with them.

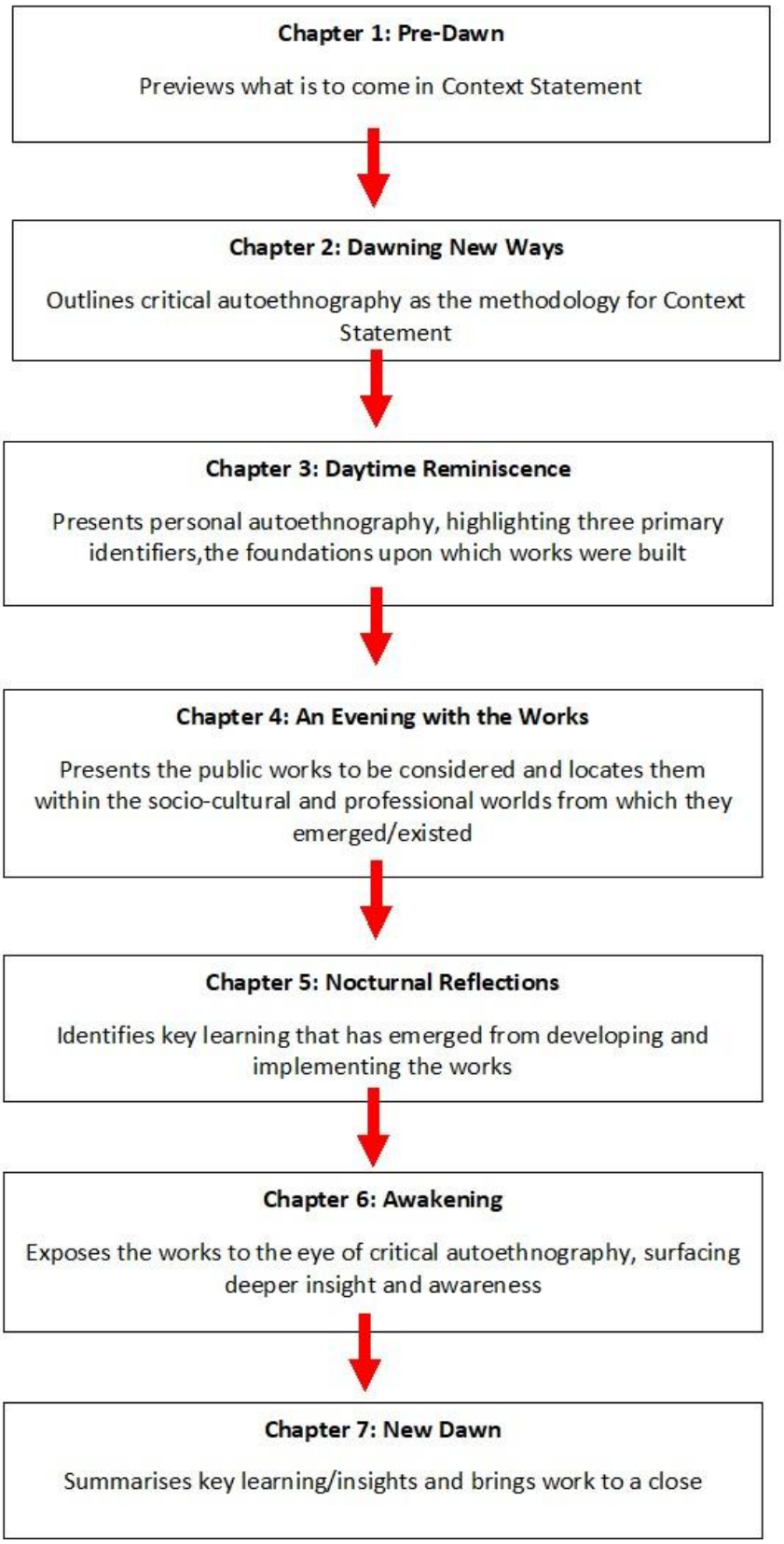
I first came across autoethnography as an innovative qualitative research methodology in the work of Tierney while completing a master’s degree in supervision back in 2014. This approach creates a space to “confront dominant forms of representation” (Tierney 1998 cited in Holt, 2003, p. 2), and it attempts to “reclaim through a reflective response, representational spaces that have marginalised those...at the borders” (Ibid.). By locating myself within the socio-cultural context through this first-person account, I hope to weave a reflexive story that respects emotional, institutional, social and cultural dimensions (see Romo, 2008, p. 179). The method offers an ideal fit for exploring both personal and professional worlds along with the tensions which arise from a rich array of life experiences. The works presented here are influenced by a life's journey; therefore, an autoethnographic approach seems appropriate to appraise them. The critique and discussion are grounded in more than half my lifetime spent working in multiple and varied roles across the Irish Health Service. This interdisciplinary fluidity undoubtedly offers an attuned eye through which to evaluate the contribution of the works.

While the focus of this statement is not therapeutic, there is undoubtedly an opportunity to explore the personal, to cleanse unfinished business, to better understand relationships with others (Boyrlorn and Orbe, 2014), and to examine the interface between the personal and professional worlds. As we commence this journey together, it is necessary that I be as honest, real and congruent as I possibly can. I begin this process with a modicum of anxiety, uncertainty, and no small measure of self-doubt. I may well have succumbed to the ‘imposter phenomenon' so eloquently described by Langford, Clance and colleagues (Langford and Clance, 1993; Clance et al., 1978). Here we go, a doctorate, 15 years in the planning, and I tell myself: “This is it, you may not be good enough, and this time they may catch you out”. Well, let's see!

Looking Forward

In this first pre-dawn chapter, I invite you to join me in a quick preview of what is to come. In Chapter 2 we will journey briefly to the world of critical autoethnography, the lens utilised to appraise the contribution of the works. In the spirit of autoethnography, Chapter 3 journeys to my personal, professional and socio-cultural roots, the foundations upon which the works were forged, fashioned and brought to life. Chapter 4 rehearses the content and processes of the works to be considered, locating them within the socio-cultural and professional worlds from whence they arose. Chapter 5 identifies key learning that has emerged from developing and implementing the works. Chapter 6 exposes the works to the eye of critical autoethnography, surfacing deeper insights and awarenesses, and Chapter 7 summates the context statement, highlights new insights, and brings us to an end, or perhaps a new beginning!

Figure 1.1: Outline of Context Statement



Chapter 2: Dawning New Ways

Getting Going

4.30 AM: It is now time to delve a little deeper into the methodology through which I propose to critically appraise the contribution of the works. Autoethnography offers a novel approach, a different vision, and an alternative lens through which to review this contribution. My journal entry from an early stage of engaging with the 'how to' of autoethnography is instructive:

> Having overcome my initial cluelessness about autoethnography with a little reading, remembering and reflection, I am now faced with the task of figuring out how to create this critical eye. Essentially, I like the approach. I find it friendly and innovative, but it remains unclear; I don't know what to do next. I am in an unfamiliar place as I value knowledge and certainty in my day-to-day professional and personal life. I am, it seems, invited into a different space – a place of unknowing.
>
> (Journal entry, November 2017)

The following account by Kim Foster of coming to autoethnography is reassuring to me:

> It is exciting to think that the process of addressing these questions should lead to a greater understanding of what I have known intuitively to be the appropriate method to foreground my research but have not as yet been able to articulate fully and substantiate in a scholarly sense.
>
> (Foster et al., 2006, p. 2)

Autoethnographic What?

Autoethnographic endeavours are presented by way of personal narrative, yet they require far more than straightforward storytelling. Autoethnography offers works that are scholarly, justified, and compiled from multiple sources. Such accounts do not rely exclusively on the author's thoughts, ideas or views; instead, they are supported by other data for the purpose of confirmation and triangulation. Methods may incorporate participant observation, reflective writing and gathering of relevant documents or artefacts (Duncan, 2004). Mcilveen (2008) broadly concurs, highlighting the value of archival materials and self-observation combined with triangulation to external sources which "corroborate data or conclusions" (p. 15). Given the value placed upon lived

experience, participant observation of self or others becomes “the core practice through which reflections are developed, and all other data collection activities are organised” (Ibid., p. 32; also see Duncan, 2004). A straightforward method of achieving this is to develop a retroactive account of the material, experiences, or work being researched. From this, key themes are developed which guide any literature review and the critical direction of writing (see Duncan, 2004).

Autoethnographers utilise methodologies which seek to interrogate and assess their own experience and consider the similarity and difference of emergent insights with those of others. According to contemporary literature, personal experience can be utilised to exemplify aspects of one’s cultural background, thus making it familiar to those who Ellis and colleagues refer to as *insiders* and *outsiders* (Ellis, Adams and Bochner, 2011). This often involves contextualising lived experience with existing research paradigms, engaging with members of a particular culture, and examining relevant cultural artefacts (Ellis, Adams and Bochner, 2011; Boylorn, 2008; Marvasti, 2006). Thus, autoethnography seeks to reflect upon multiple and varied viewpoints, incorporating social roles, the criteria by which we adjudicate ourselves and our primary self-attributed cultural identities (Chang, 2008). It essentially creates a foundation for the author to reflect upon, analyse, and interpret their broader socio-cultural and political context (Ibid.). Ellis and Bochner (2002) suggest that such autoethnographic processes allow us to “self-consciously explore the interplay of the introspective, personally engaged self with cultural descriptions mediated through language, history and ethnographic explanation” (p. 742). Caroline Ellis and her colleagues contend that the author reflects upon past experiences through retroactive and selective writing (Ellis, Adams and Bochner, 2011). Simply put, this method, falling clearly within the genre of qualitative inquiry, brings the self (auto) within a cultural context (ethno) into the research process (graphy), allowing us to bring our personal experience to “the centre stage in the investigation” (Chang, 2008, p. 45). Such endeavours frequently create epiphanies: critical intuitive or perceptive insights and moments of awareness. These moments, often emerging from life crises (Ellis, Adams and Bochner, 2011), may be somewhat akin to what Mezirow (2009) describes as transformative learning experiences. When autoethnographic researchers retrospectively write about these epiphanic moments, they recognise that they are

located within a broader socio-cultural context and that they arise from living within a culture or holding a particular cultural identity (Duncan, 2004).

As the author of the current work, my old ways of being, my needs for convention and familiarity, lead me towards an analytic tradition which demands that autoethnographers critically examine their experiences (Ellis, Adams and Bochner, 2011b; Anderson, 2006). Within this genre, we need to "look at [our] experience analytically. Otherwise [we are] telling [our] story—and that's nice - but people do that [...] every day" (Allen, 2006, cited in Ellis, Adams and Bochner, 2011, p. 276). Chang's (2008) work is instructive here where she advises careful consideration at the early stages, as a "plan needs to delineate why and how you want to explore your own life and what you want to explore in it" (p. 61). As I read Chang's account, concreteness and a little clarity begin to emerge, only for me to be dropped back into uncertainty with her proposition that this type of research is "never neatly linear or sequential" with "steps often overlap[ping] and mix[ed]"(ibid.). A key challenge that arises then is how to position oneself in relation to the work. Chang (2008) offers three possible options: (i) investigating one's life story, with self as the main character, (ii) including others as co-participants in the study, or (iii) simply studying others. In Chang's analysis, the first "seems most common in autoethnography", with "others...explored...in auxiliary relationships with self" (p. 65). This essentially places autoethnographers as "narrators, interpreters, and researchers of their personal experiences" with others in roles of "supporting actors occupying the fringes of [the] authors' stories" (ibid.). Foster et al. (2005) favour such a proposition, highlighting the importance of locating the "self as the starting point for the study...alongside the experiences of participants" (p. 5).

As I progress in my exploration, uncertainty looms. This approach sits awkwardly with conventional wisdom on the pursuit of knowledge within the healthcare world. My reflections from an earlier encounter with autoethnography as a methodology highlight this tension:

> I am enthralled and enthused. This method ticks all the boxes for my transformative learning, community education and person-centred ideologies. I wonder though how it will go down at work: a bit woolly and unstructured, and a bit far left I'd say!
>
> (Journal entry, March 2014)

Almost all of my professional training cries out for some order and 'traditional' authenticity. Chang (2016) offers just that. By way of establishing a standard for research within healthcare, she suggests five strands for adjudicating the quality of autoethnographic research. These include: providing authentic and trustworthy data, having an accountable research process, maintaining an ethical position, engaging in socio-cultural analysis and interpretation, and making a scholarly contribution (see Appendix II). Mcilveen (2008) proposes that autoethnographic work should "meld theory and the autobiographical reporting of experiences" (p. 16) in order to create a comprehensive interpretation of the authors experience, have a transformative impact, and inform readers of experiences which may be new to them or which they have experienced but are unable to share. Within this version of events, the author seeks to present an autobiographical account which is "enriched with theory", so that "the reader is more likely to construct lessons for his or her own sphere of practice", while emphasising "empathic resonance" (Ibid.).

Reflection and Reflexivity

Given the amount of personal and professional reflection embedded in this context statement, some clarity of terminology may be useful; in particular a distinction between the terms *reflection* and *reflexivity* is warranted. My experiences of both reflection and reflexivity emerge from working as a nurse, teacher, counsellor and supervisor. Within these contexts the term reflection is viewed broadly in line with Hibbert's (2015) proposition which incorporates 'thoughtful questions' about an issue that we wish to better understand or an inquiry that seeks to solve problems. In my own experience reflection may be either a personal or a shared journey which is somewhat introspective in nature without significant reference to the social context, environment or broader community of practice. Bolton (2010) concurs that it may be either a 'solitary activity' or occur with 'critical support' (p 13). Within such reflective activity, we may consider or write about particular experiences and explore how we have grown and developed, with the hope of fostering changes in our ideas and practices. This often occurs in supervision, learning sets, journal clubs and within reflective practice groups. Bolton (2010) proposes that such reflection involves learning though detailed examination of our perceptions of issues or situations, along with our

sense of how others perceive them, with the expectation is that it opens our practice to scrutiny, and draws from a wider body of knowledge.

As I rehearse these concepts, I am drawn in my mind's eye to Dewey, Piaget and Schon, all of whom feature in the evolution of my thinking on reflective processes. In particular, Schon's (1983) notion of the *reflective practitioner*, which is widely used within my field of practice, invites a circular perspective where feedback loops link theory and application to practice. Some propose that Schon's concept of reflecting *on action* versus *in action* offers some distinction between reflection and reflexivity. Rolfe et. al., (2001) writing within a nursing context posit that if we reflect *on action* then perhaps we are being reflective and if we reflect *in action*, then perhaps we are being more reflexive? This rudimentary distinction is critiqued by Thompson and Thompson (2008) who see reflection as an analytical activity and reflexivity more as a process of self-awareness. Glanville (2013) conceptualises reflexivity in terms of embracing the ideas and reactions of others into our own self-appraisals. Similarly, Von Foerster (1991) talks in terms of seeing ourselves through the eyes of others.

These descriptions of reflexivity may well be critiqued for their failure to recognise the extent to which we shape and are shaped by our social world. Sandelowski and Barroso (2002) propose that reflexivity involves looking inward as an inquirer whilst contemporaneously looking outward to the socio-cultural, historical and political forces that shape us and the social interactions we share with others. Similarly Thompson and Thompson (2008) define reflexivity as "...an ability to recognize our own influence – and the influence of our social and cultural contexts on research, the type of knowledge we create and the way we create it" (p 20). Bolton (2010) argues that reflexivity includes consideration of how others view us and our shared world, and how this influences the view we hold of ourselves and our actions. This may involve questioning our thinking, attitudes, assumptions, values, habits and prejudices and teasing out our understanding of our role in relation to others (ibid).

Whilst these theoretical analyses offer some clarity, contemporary distinctions between reflection and reflexivity remain far from clear (Hibbert, 2015). The work of Scaife (2010) on 'reflective practice', Mezirow (2009) on 'transformative learning' and Brookfield (1995) on 'critically reflective practice' brings a more critical eye to reflective

processes. However they tend to evade clear distinction in both their analysis and interpretation. Terms like *reflection, critical reflection*, *reflexivity, reflective practice* and *critical reflexivity* pervade the literature and are used interchangeably in practice. Therein lies what I experience as *coal-smoke*; blackening, spoiling, clogging the breath of knowing. Perhaps in my everyday practice, I also have a somewhat fudged view of these important concepts, often overlapping and unclear in my interpretation of both. Berry (2013) acknowledges the contested nature of reflexivity, noting that "understanding and working reflexively often are complex, knotty ... processes" (p 212). Archer (2007) concurs on the uncertainty that surrounds the term reflexivity, suggesting that "... because [of] the terminology that subsumes reflexivity... the process denoted by reflexivity has been underexplored, undertheorised and, above all, undervalued... (p. 1). Thomson and Thomson (2008) caution us to avoid allowing the similarities between reflection and reflexivity to confuse us into thinking that they can be used interchangeably.

My engagements with health related qualitative research suggests that a 'reflexive stance' is considered to be one that incorporates an exploration of how our own beliefs and values impact upon the study, allowing us examine the lens through which we view others and the research process itself. This is somewhat akin to Lather's (1991) notion of leaving our 'fingerprints' upon the research. Essentially when qualitative researchers take what they see as a 'reflexive stance', they consider how they influence the research and the setting and how the research setting influences them and their research. This invites a critique of how their beliefs, attitudes and experiences affect the study as a whole. What questions do we ask? How do we collect the data? How do we interpret the findings? Thus it becomes imperative that readers can see the researcher in the research process. This in my experience is often seen as a mechanism for limiting or eliminating subjectivity. As I rehearse these concepts, which are reasonably standard practice within qualitative health service research, it becomes apparent that they sit awkwardly with an autoethnographic stance, in that they lack the combined effort of looking both ways and embracing the socio-cultural-political milieu. The work of Archer (2007) suggests two conditions necessary for reflexivity to occur (i) the object being considered is 'bent back' upon the subject considering it and (ii) a concern with 'social

matters' or consideration of 'people and society' prevails (pp. 2-3). She defines reflexivity as "... the regular exercise of the mental ability, shared by all normal people, to consider themselves in relation to their (social) contexts and vice versa (p. 4).

Autoethnography celebrates the subjective, looks inward and outward, and embraces the social context. Autoethnographic inquiry recognises that processes of investigation and outcomes alike are heavily influenced by deeply subjective personal and professional reference points, imbued with cultural experience. The sterile, apolitical stance of much contemporary research falls well short of this autoethnographic standard, which values and indeed embodies lived experience. Reflexive processes and outcomes are therefore imbued with gender, race, spiritual beliefs, class and a whole range of the contextual experiences of both the author and others. Holman-Jones and colleagues (2013) referring to the work Pathak conceptualise this in terms of "identifying systems that shape, constrict, disrupt, inform both the story and the storyteller in autoethnography" (p 31). Berry (2013) calls us to question the relationship between the self (the researcher) and others. This draws us away from uncritical acceptance of positivist ideology and power systems towards an acknowledgement of the reality that we shape and are shaped by investigative processes, a practice that occurs in dialogue with readers, participants and collaborators alike. We can therefore no longer speak for others. We voice our truth, sometimes alone, sometimes in collaboration, but always aware that we and others form part of a collective socially and culturally constructed, interconnected, and finely weaved story. This socially conscious, politically aware position invites us to give a voice to those who are silent and to shape social and structural changes.

An autoethnographic stance also values intuition and emotional engagement within the author and in relationship with the reader, a concept of which (in my experience) many contemporary reflective models are devoid. Moon (2004) offers an interesting perspective, where she critiques the tendency of western culture to "to emphasize... analysis and problem solving, not negotiation nor contemplation" [and to seek] "...detachment, objectification and non-involvement of emotions" (p 61). Perhaps what is needed is an acknowledgement of emotion as a mediator of reflexive processes? Referring to the work of Korthagan (1993), Moon introduces the idea of

'non rational reflection' which embraces creative 'outside the box' perspectives imbued in 'right hemisphere thinking' where rational logical thinking is bypassed. Introducing the term 'holistic reflection', which includes poetry drama, dance, and writing she posits that we can bring forth, ways of knowing that are not accessible in traditional modalities (ibid). Holman-Jones and colleagues (2013) coin the term *Mimesis,* pitching autoethnography as a "mirror or reflection of life and living in ways that are useful for contemplation as well as a mode of engagement with understanding" (p 38). Referring to the work of Art Bochner, they consider this an inquiry that puts 'issues of being' into 'circulation and dialogue'. This is followed by a call for *Poiesis* or a desire to "...make something happen..." (ibid), or in Berry's (2013) analysis, to make research culturally better and more meaningful, allowing both critique and transformation to occur. By engaging in such praxis we may situate ourselves distinctively within the story and imagine not simply what has been achieved but also what could be done. Alexander (2013) talks of *Kernel* or transformative moments and their potential as part of reflexive processes. This incorporates constructing a story by identifying, describing, and establishing the socio-cultural-political context through critically contemplative processes (p 547). This may incorporate exploration of the milieu, power structures, ones position in the story, orientation, and how the self and others are represented.

For the purpose of the work at hand, this contemplative thinking, this reflexivity, is not simply an option, but indeed a requirement. I trust that this work embraces a reflexive stance; one that takes nothing for granted, tells the story, asks difficult questions, looks outward, 'bends back' on the self, locates the public works within their socio-cultural-political context, explores power structures, embraces the creative, is emotional, invites personal transformation, and calls for social action.

The Harvest

Momentarily I sift through yesterday's post and come across a book purchased on Amazon, a treatment manual: a familiar sight, clear, concise and to the point, fitting with my need for structure, reliability, and order. In a parallel universe, my mind wanders back to what this autoethnographic product might look like. Autoethnographers generally attempt to "produce aesthetic and evocative thick descriptions of personal and interpersonal experience" (Ellis, Adams and Bochner, 2011,

p. 277). This can be achieved by identifying patterns of cultural experience located in notes, journals or other artefacts (Lucero, 2018), and then discussing them through storytelling. Key to this process is producing accessible texts and at the same time elucidating subtle relationships and interactions within and between the personal, interpersonal and cultural domains. Thus, autoethnographic texts should be personal, meaningful, engaging, and appealing to a broad audience (Goodall, 2006) that "traditional research usually disregards" (Ellis, Adams and Bochner, 2011, p. 277). While all this sounds reasonable and perhaps even rational, it is a far cry from my treatment manual which now cuts a lonely figure upon my desk. My journal reflections pinpoint yet another challenge emerging from my professional world, a call for somewhat more traditional academic discourse:

> This begins to paint a picture; however, if I am to proceed and at the same time keep my community of practice on board, I need to dig a little deeper, present a balanced analysis: the ups, the downs, warts and all of this methodological process.
>
> (Journal entry, December 2017)

The Ups

As the 1980's progressed, postmodern researchers became increasingly aware of the need for reform in social science research, with an effective crisis of confidence emerging, forcing scholars to acknowledge that recognised givens, facts, and truths were intimately connected to the belief systems of those who sought to represent them (see Ellis, Adams and Bochner, 2011b; Lather, 2007; Lather, 1991). While many social science researchers still aspire to neutrality, impersonality, and objectivity, most now recognise that such suppositions are implausible. This paradigm shift has opened the door for autoethnographers to conceptualise how lived experience impacts upon and indeed shapes the investigative process. As a methodology, autoethnography recognises and celebrates subjectivity and emotional engagement, and it acknowledges the researcher's influence on the investigative process (see Lucero, 2018; Ellis, Adams and Bochner, 2011; Lather, 2007; Lather, 1991).

Traditional scholarship tends to favour those who advocate for and reflect dominant ways of knowing which are generally "white, masculine, heterosexual, middle/upper classed, Christian, [and] able-bodied" (Ellis, Adams and Bochner, 2011, p.

275). Utilising these methodologies, researchers and writers tend to ignore and undermine alternative ways of knowing. Conversely, autoethnography seeks to open up a broader lens, avoiding "rigid definitions of what constitutes meaningful and useful research" (Ibid.). This expands our understanding of who and what we are, and how our self-perceptions can influence our interpretation and analysis of 'facts' (Ellis, Adams and Bochner, 2011; Wood, 2009; Adams, 2005). Chang (2008) identifies three areas in which the autoethnographic method is beneficial: (i) it provides a methodology that is "friendly to researchers and readers alike", (ii) it facilitates "cultural understanding of self and others" and (iii) it carries the potential "to transform self and others to motivate them to work toward cross-cultural coalition building" (p. 52). Ellis, Adams and Bochner (2011) add the therapeutic value of writing personal stories for both the writer and the reader as a clear advantage of the method. Reflections from a previous encounter with autoethnography mirror some of these affirmative propositions which emerge from the literature:

> The inherent benefits articulated by Chang become more evident as I reflect upon the journey so far. I certainly experience the method as friendly, as in fairness, most qualitative methods are to me. Working in the mental health arena, where a qualitative perspective is valued, allows the pursuit of this way of knowing. It is clear to me that in understanding myself and my world, I can better understand others concerning their sameness and difference.
>
> (Journal entry, April 2014)

Of course, while positive benefits accrue, like all methodologies, autoethnography also presents a shadow side.

The Downs

I must confess that I find myself wondering will this stand? Will it meet the standards of the professional world within which I operate? Will the data, if it is data, be robust enough? Will it have any claims to objectivity, or should it have? Will I be the researcher and the researched? Will the findings inform my area of practice? Will this work have credibility? At least some of this muddle of concerns is addressed in the contemporary literature. Autoethnographers are frequently measured against the doctrines of traditional social science research, with critics holding autoethnography "accountable

to criteria normally applied to...ethnographies or to autobiographical standards of writing" (Ellis, Adams and Bochner, 2011, p. 282). Consequently, autoethnography frequently satisfies neither scientific nor artistic expectations (Ellis, 2007). Within this philosophical crevasse, autoethnographic work is frequently challenged for lacking in rigour, theoretical robustness, analysis, and sufficient field work, combined with a perception of bias and self-absorption on the part of the writers (see Delmont, 2009; Anderson, 2006; Madison, 2006). Simultaneously, accusations of lack of imagination, lack of creativity, and disregard for literary mores are frequently levelled (Gingrich–Philbrook, 2005; Moro, 2006). Many of these dualistic critiques paint a black-and-white world where the arts and sciences are at odds. Thus, autoethnography increasingly needs to create a space where these binary distinctions between art and science begin to fade, with proponents arguing that autoethnography "can be rigorous, theoretical, and analytical and emotional, therapeutic and inclusive of personal phenomena" (see Ellis, Adams and Bochner, 2011, p. 283). For autoethnographers, the audience, the impact, and social justice are far more important than focusing excessively upon objectivity and accuracy (Ibid.), with the overarching aim being to "produce analytical, accessible texts that change us and the world we live in for the better" (Holman-Jones, 2005, p. 764).

Chang (2008) identifies some potential shortfalls of this approach. In her view, there may be excessive emphasis on the researcher's perspective with exclusion of others views. Therefore, undue emphasis may be given to "narration rather than analysis and cultural interpretation" (Ibid., p. 54); there may be exclusive reliance upon "personal memory" and recall as data sources; and there is often a lack of regard for ethical standards in management of data (Ibid.). Ellis, Adams and Bochner (2011) concur on some potential pitfalls including (i) ethical issues of research participants being identifiable, (ii) the challenges of subjective interpretation, and (iii) potential for bias in data. They also point to inherent problems with reliability as the 'truth' changes over time. Clandinin and Connelly (2000) acknowledge the possibility of distortion of memory, but they note a tendency towards a smoothening or balancing of the landscape over time. Mcilveen (2008) addresses some challenges which may arise from the relationship between the "knower" (participant) and the "would be knower" (researcher), with significant limitations to "self-knowledge" and "self-report

narratives" (p. 16). These can, of course, be ameliorated through faithfulness to standards or quality and rigour in the methodology (Mcilveen, 2008; Chang, 2008; Morrow, 2005). Mcilveen (2008) argues that, while autoethnography has “no rightful purchase on generalisability[,]...it has the potential to act as a stimulus for a profound understanding of a single case” (p. 16), thus stimulating new intellectual perspectives for readers through “uniquely personal meaning and empathy” (Ibid.). Reflection upon these methodological challenges highlights the need for the maintenance of high standards in autoethnographic works.

Ethical Sensitivity

As a healthcare worker, ethical considerations always loom high on the agenda. As I reflect upon ‘doing the right thing’, a short poem emerges:

> ***Auto-ethics***
> How to do this autoethnography with others,
> for others, for us, for me,
> not to others.
> That’s the challenge.
> How to move beyond rules and regulations.
> Dictums of the past, orders,
> how to be with others together.
> That’s the challenge.
> All informed and agreeing,
> do no harm,
> privacy, privacy,
> Safe, secure, respected.
> That’s the challenge
> Within context, changed and
> Transformed.
>
> (James O'Shea – cited in Journal entry, January 2018)

As autoethnography's primary focus is on the self, my initial impression was that common ethical concerns might not apply, a misconception noted by Chang (2008). As I proceed to conceptualise the ethical considerations, the above poem captures the essence of my desire to foreground honesty, transparency, and integrity in the work.

Again, like all endeavours that require a critical eye, it becomes clear (clear as mud perhaps!) that this is both complex and multi-layered, with eminent authors like Clandinin and Connelly (2000) questioning our exclusive ownership of the story based solely upon our authorship.

As authors, we are not located within a social vacuum so that "when we conduct and write research, we implicate others in our work" (Ellis, Adams and Bochner, 2011, p. 280). These challenges are heightened when we write autoethnographically, as we may allude to "close...intimate others" (Ibid.). It is clear then, that other people always emerge in our self-narration (Chang, 2008) either by active participation or association (Morse, 2002). As we engage in the work of sharing our stories in a far more personal way than in traditional social science research, it becomes difficult to avoid drawing personal dynamics into the light (see Ellis, 2007). In the complex role of "researcher, informant and author", we will do well to remember that our research "is never made in a vacuum" (Chang, 2008, p. 69). This is further complicated by the bonds we hold with those who emerge in our stories, as they are not simply "impersonal subjects to be mined for data" (Ellis, Adams and Bochner, 2011, p. 280). As a consequence, managing our relationships and associations with these people becomes essential (Tillmann, 2009), with tending to significant relational issues coming centre stage in the investigative process (Trahar, 2009). These requirements set autoethnographers, as academics, apart from other authors and journalists, assigning us a primary responsibility to protect the people involved in our studies (Tolich, 2010).

Tolich (2010) argues that, in advancing our ethical considerations, we must explore the ethical boundaries between ourselves and others and anticipate emerging dilemmas. In Tolich's view asking "who would be offended by what is written?"(p. 1605), helps us to become more sensitive and brings our attention to impending harms that may arise. Medford (2006) offers the advice that we should not publish materials that we would not show to the people implicated in our research. Tolich (2010) offers two cautions: choosing the topic carefully, and treating all participants in the process as vulnerable, including the author. He invites us, when writing about sensitive issues, to "imagine dressing up in sandwich boards and walking around...proclaiming our stigma" (p. 1605). In the words of Pontius Pilate, what I have written, I have written. Now that is sobering! A troubling reflection emerges:

> Once this work is uploaded to the university hub, it is no longer mine alone. It becomes public property, with myself and all of my collaborators potentially paraded in front of the world.
>
> (Journal entry, January 2018)

This fear needs to be considered in light of the counterbalancing ethical imperative of remaining true to the story, the critique, and its transformative potential. In Janice Morse's (2002) analysis, our goal should be to minimise the risk to those involved and at the same time not silence the story and its potential.

Ellis (2007) addresses issues of exposure in discussing the rights of authors/victims to come to terms with their experience, She poses a critical question: "Then I ask myself, is the wellbeing of the researcher always less important than the wellbeing of the other, even others who have behaved badly? I answer 'No not always'" (p. 24). Tolich (2010) in critiquing the work of Ellis considers such analyses to be too vague, and he points to the need for clarity in separating our personal experiences from the writing process in anticipating ethical issues. Chang (2008) urges consideration of those along with the author who have rights in the story and of how risk can be minimised once it is identified. Martin Tolich's "Ten Foundational Guidelines" (2010, pp. 1607-1608) covering consent, consultation, and vulnerability are instructive for the ethical practice of autoethnography (see Appendix III). Carroll's model of ethical maturity and ethical decision making (Carroll and Shaw, 2013; Carroll, 2011a; Carroll, 2011b) also offers a guide to the journey of making mature ethical decisions. In the Irish context, the *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives* (NMBI 2014) offers clear guidance in the maintenance of ethical standards. These frameworks are useful in illuminating a path towards ethical discernment and the **'**protection of self and others' within the autoethnographic process (see Appendix IV for further details). Having reflected and sometimes wrestled with these concepts, I have set about designing a methodology which I hope will present the works addressed here in an honest, fair, and ethical manner. Another recent reflection highlights my ongoing struggle with the 'how to' of ethical maturity for this current work:

> That all sounds good, reasonable, rational, I think? But my real challenge is to see how I can bring this home. I am in a familiar unfamiliar territory. Here I go, caught again in my hybrid world. On the one hand an objective, logical, scientific approach calls – safety, security, order, stability. On the other hand, I am called forth to step up, to meet that now familiar howling for creativity – outside the box, beyond the square, making a more congruent, authentic and transformative contribution. (Journal entry, January 2018)

My long years of working in the public service leave me with a level of frustration at the sometimes sterile 'box-ticking' approach taken to ethics in healthcare. Ethical considerations must, of course, go well beyond 'doing no harm', not upsetting the proverbial apple cart, and not breaking the rules. It is reasonable to argue that we must also do something useful, something meaningful, and at the very least something that is *potentially* transformative. Within this context, we may "focus on using...dilemma[s] to help grow...ethical capacity" (Hawkins and Shohet, 2012, p. 134) and foster what Bond (2015) calls ethical mindfulness. It is, in fact, an ethical imperative that we create a space within ourselves, our participants, and readers alike that opens up the potential for transformative learning, offering what is referred to in supervision circles as "a super way of visioning "where "with new visions come new perspectives and new meanings" (Hawkins and Shohet, 2012, pp. 21-22). Weld (2012) conceptualises this transformation as interrupting our thinking so that "a new possibility emerges" (p 21). We are invited to draw upon new meanings and new perspectives (Shohet, 2011; Mezirow, 2009) and to progress far beyond mere educational, therapeutic, or research goals. Within this analysis, transformation becomes a measure, a yardstick by which we adjudicate ethical practice (O'Shea, 2014). It is also clear from the literature that, in addition to transformative ideals, mature ethical decision making requires focused attention, cognitive and emotional engagement, intuition (Carroll and Shaw, 2013), and a commitment to taking responsibility (Bond, 2015).

Towards an Epistemological Position

As the public works begin to be addressed in greater detail in chapter 4, you will discern the use of a diverse range of philosophical positions and theoretical orientations. The person-centredness of the SAOR model, the structure of CBT, the developmental nature of supervision, and the more radical recovery education co-exist within my professional repertoire. This hybrid, even magpie, orientation is puzzling and disconcerting for many within my community of practice. For me they sit comfortably in an awkward kind of way. These diverse models, at times gliding gently and occasionally bumping clumsily, always generate a creative tension.

Personally, professionally and developmentally a person centred orientation feels familiar and comes naturally to me (see personal autoethnography in chapter 3). More recent engagements with autoethnography challenge this evocative stance; inviting more co-creation of knowledge (see Holman-Jones et. al., 2013). Years of practice within the substance misuse field illuminates the need for more structured interventions (UKATT Research Team 2005; Project MATCH Research Group, 1998). I have also found myself drawn to Motivational Interviewing which offers a somewhat more structured guiding style (see Miller and Rollnick 2013); an opportunity for collaboratively shaping knowledge, understanding and co-creating potential change. Motivational Interviewing has become a stepping stone and ultimately opened a pathway to CBT which has a strong traditional evidence base within my field of practice (O'Shea and Murphy 2015, Miller et. al., 2003). Dissatisfaction with CBT's perceived emphasis on therapist expertise draws me towards mindfulness based cognitive approaches (Teasedale et. al., 2014; Williams and Penman 2011) which in my view offer a gentler, more compassionate and accepting stance. Struggling to 'think outside the box', calls forth the theory and practice of adult education and transformative learning (Mezirow 2009; Freire 2005) and nurtures a social consciousness in the work (see appendix vii and appendix viii). Engagements with transformative learning constantly create a disturbance that calls taken-for-granted assumptions into question, or as one colleague puts it, my 'inability to simply leave things alone'. In considering these dynamics it becomes clear that motivational interviewing, mindfulness and transformative learning ideas create philosophical bridges which facilitate the

simultaneous holding of what are divergent and sometimes conflicting ideological positions. Essentially they create a space that embraces humanity, reflective practice and inquiry, while at the same time maintaining a level of professional homeostasis. As practitioners, while we embrace reflective practice, we are often devoid of a reflexivity that locates the work within its broader socio-cultural-political frame. We are lacking in a cultural praxis that looks with clarity; one that threatens to change the professional world that we live in.

This current role of doctoral researcher requires higher order thinking and calls for a deeper, more integrative and more culturally aware critique, one that invites a journey beyond the practitioner, teacher or developer of practice based models. In attempting to bring a more critical eye to bear upon the works, autoethnography offers yet another philosophical bridge, one that evokes a new level of critique and understanding; one that unbalances and challenges professional norms, one that seeks to co-create knowledge and calls for action. In the words of Denzin (2017), "there is a need to unsettle traditional concepts of what counts as research, as evidence, as legitimate inquiry... [and]...expose and critique the forms of inequality and discrimination that operate in daily life" (p 8). This begins with an invitation to present accounts of professional practice that acknowledge the humanness to the work (Peseta, 2005) and contemporaneously question taken-for-granted uncritical projections, stories and preconceived notions of the self (Bochner 2002). In the words of Brodkey (1996) it invites us to "...see [ourselves] as human subjects constructed in a tangle of cultural, social and historical situations and relations in contact zones" (p. 29). As we weave this story it is imperative that difference and commonality are deliberately addressed rather than omitted or dismissed in the process of making meaning of our experience (Foster et. al., 2005). In so-doing we attempt to take an honest look, that holds the self and culture together in a world of continuous fluctuation (see Holman-Jones, 2005).

The autoethnographic writing process creates deeper understandings of the interpersonal (Wyatt 2008), acts as a catalyst for taking self-responsibility, develops self-understanding, facilitates personal development, creates agency, develops empowerment and promotes social and cultural action (Kiegelmann, 2010; Goodall 2006). Adams and Bochner (2011) contend that this act of witnessing engages the

author, participants and readers alike in testifying on behalf of events, problems and experiences. Cultural contexts including those that have influenced our thinking and behaving, both spoken and unspoken, are explored by writing in ways that allow us to identify issues that may be harmful or held in secrecy (see McCurdy et. al., 2005).

As the story of these public works unfolds, both intrinsic and transtheroetical tensions will emerge. The person centred approach which locates knowledge, wisdom and the ability actualise innate potential (Mearns and Thorne, 2007; Rogers 1961) has been criticised for lacking in a critique of issues related to abuse, violence, exclusion and power imbalance (Chantler, 2004). Within this context one may see the person centred approach as deficient in social critique, being overly introspective and lacking in dialogue with ones broader community. Even though more recent iterations of CBT emphasise collaboration and the utilisation of peoples internal resources (see Greenberger and Padesky, 2016; Gilbert, 2014), much contemporary practice remains substantially therapist led, vesting knowledge and 'objectivity' within the professional domain (Proctor, 2008), with the potential to propagate professional power and privilege. Supervision serves numerous core functions including *normative* (oversight), *formative* (learning) and *restorative* (support) dimensions (Proctor, 1986), yet an overly vigilant bureaucratic organisational culture can suffocate its developmental potential (Hawkins and Shohet, 2012). Supervision may well be, and perhaps often is, utilised as a means of controlling staff and ensuring that they operate within a defined space that maintains organisational homeostasis and control. The recovery approach, emerging as a radical response to the dominant medical model has been criticised for being ineffective in gaining a significant foothold within mental health practice (Field and Reed, 2016).

So what then is required if we are to move beyond the limitations of our contemporary models of research and practice. Denzin (2014) suggests that "the challenge is to develop a methodology that allows us examine how the private troubles of individuals are connected to public issues and to public responses to these troubles" (p. vii). An autoethnographic stance allows us to reconnect the personal and social dimensions of our existence and dispels the positivist myth of objective scientific truth. It draws those at the margins to the centre and gives voice to people who have been

silenced by our contemporary understandings of evidence and scientific inquiry (Hackley, 2016). Embracing a humanistic spirit it treats all those in the story as having value in their own right (ibid). In Denzin's (2014) analysis, our writing "...must always be interventionist..." (p. 6) giving a voice to people who might otherwise be silent or find themselves on the 'wrong side of the tracks'. For me this signals an epistemological shift from practitioner to researcher, from consumer of taken-for-granted uncritical assumptions to a more reflexive space that positions the self inside the research process; a move away from an 'objective stance' which demands that the self be 'excised' from the research (Freeman 2017, p. 17).

This invites a move from objective outsider to informed insider. The invitation is to utilise rather than excise ones personal, professional and cultural identity. From a health care perspective numerous authors have made this transition, melding the personal, professional and socio-cultural. Within mental health nursing Kim Foster utilises autoethnography to explore her experiences of growing up with a parent who had psychosis (Foster et. al., 2005). Grant (2010) explores his own mental health difficulties as a prelude to discussing autoethnographic ethics. Bartlett (2015) utilises autoethnography to explore the use of mindfulness meditation during psychotherapy training. Appraising the contribution of the diverse range of public works considered here requires a contemplative stance; one that contextualises, creates, invites, and calls for a different kind of investigation; an inquiry that transforms the self and invites reform of the professional world; one that moves beyond traditional scientific inquiry to straddle the personal, social, cultural, and political worlds; the wholesome, flesh-and-blood, lived experience of research and practice.

Putting the Bits Together

10.15 AM: As I reach mid-morning, I am keen to tie things down, to gain further clarity on the 'how to' of this context statement. My consideration of the works has evoked much soul-searching in recent years, most of which, I have to admit, has been less than purposeful and often ramshackle in nature. In addressing this issue more purposefully, I begin to settle more comfortably upon utilising autoethnography as the critical lens through which to view the works and their contribution to my personal and professional worlds. In the words of Chang (2008), I am now "willing to dig deeper into

[my] memories, excavate rich details, bring them into examination...to sort, label, interconnect and contextualise them in the socio-cultural environment"(p. 51).

Table 1: Methodological Approach for Context Statement

Artefacts: Within the context statement, I present the public works and outline their development. Full copies of the works for consideration have been uploaded onto the university hub. Visual images, including timeline diagrams, are utilised as a means of mapping and condensing the evolution of the works, including significant points along the journey. Complimentary artefacts that have triggered memories, observations, and reflections are presented throughout the context statement in the form of excerpts from my personal journals and poetry.

Personal Data: Broadly speaking, I present three types of personal data including (i) personal memories, (ii) self-observation, and (iii) personally-reflective material. Data from formative socio-cultural experiences is captured in a systematic manner by way of an adapted *culture gram* exercise (see appendix IV). Selected personal memories relating to the evolution of the works, along with some of the pertinent contextual issues that shaped them, are presented as *Stories from the Western Front* (see Appendix VI for stories). This data, opening a door into rich and diverse past experiences, represents important building blocks that situate the works within my lived experience. Present moment self-observation provides insights into the journey through this doctoral proposition, revealing changes and continuity in my personal and professional perspectives over time. This real-time observation shines an inquisitive light on emotional issues, thought processes, and overt and covert personal, organisational, and societal patterns.

Personally Reflective Material: This purposefully invites me towards intentional self-analysis and critical reflection upon the personal, societal, and organisational dynamics which have shaped the works. A kind of 'critical curiosity' arises from engagement with both past and present-centred experiences disrupting the mundane, embracing the extraordinary, and capturing 'light bulb moments'. This invites new levels of awareness of myself and others and welcomes 'disorientating dilemmas 'as valid opportunities for learning and cornerstones for future developments.

Literature Review: In keeping with other qualitative methodologies, the task of validating and contextualising lived experience within my field of practice emerges from robust engagement with appropriate literature. Within the context statement, I embrace a broad swath of literature

drawn from the fields of autoethnography, transformative learning, person-centred approaches, policy issues, and organisational dynamics so as to provide a theoretical underpinning, rational, and framework for the study. Through this process, I contextualise the public works by tempering awareness of internal subjective experiences with the relative objectivity of peer reviewed international publications.

***Cultural Analysis*:** Key themes and epiphanies are explored through the critical lens of autoethnography, acknowledging the broader socio-cultural context from which the works emerge with the aim of drawing out key learning and conclusions. Within this context, culture shaped by our interactions with others is broadly recognised as the way in which we perceive ourselves and our world, including the ways we behave and evaluate our experiences and interactions with others.

Protection of Self and Others: In order to maintain ethical sensitivity and protect all those implicated in this reflective process, I have undertaken a number of practical steps including gaining informed consent from those implicated in the writing, maintaining confidentiality, engaging in ethical consultation with others, preventing harm, assuming exposure, and ensuring that I can stand over the work (see appendix IV for further detail).

In a Nutshell

10.45 AM: As coffee break looms and I bring this chapter to a close, a summation may be useful. This chapter has offered a brief overview of autoethnographic practices and processes, identifying what may traditionally be referred to as both their strengths and limitations. This is followed by a process of discernment, culminating in the development of an ethical framework for this context statement. The chapter closes with an outline of the methodological approach utilised. It sounds a bit like the methodology chapter of a traditional thesis, doesn't it? Therein lies the struggle, between my screaming desire for radically transformative methodologies and the enculturation forged by more than half a life lived in the middle ground of Irish public service. My cognitive, rational self strives to fix this, cover it up, and extinguish the discordance. Today I will acquiesce to a quieter inside voice, allowing myself to rely more upon gut feelings. For this morning at least, I will trust my instincts and stick with a process that leads to significant 'toing and froing' between my personal, professional, and social worlds with the hope of transforming this material into a coherent reflexive

story. I will stick with this process, however uncomfortable, and to trust emergence. On the cusp of mid-morning, and with a break from this frenetic pace over-due, I now fully commit myself to this autoethnographic journey.

11 AM: Time for coffee! Once we return, Chapter 3 will present a personal autoethnography, reflecting the primary identifiers that form the foundations and fashion the cornerstones for the works presented in this context statement.

Chapter 3: Daytime Reminiscence

Fingerprints

> I presume you may…wonder how I came to engage in [this] occupation…Let me see if I can give you some of the psychological highlights of my autobiography, particularly as it seems to relate to my professional life.
>
> (Rogers, 1961, p. 5)

11.30AM: In the rough and tumble of this doctoral journey, a coffee break has provided space for rest and reminisces, allowing time to gain some insight into the drivers of my personal-professional worlds and the impact they may have upon the works considered here. As the morning progresses, I invite you to share in the process of locating lived experience at the centre of this reflective journey. So, let me tell you a little about my own social fingerprints by presenting reflections based upon a culture-gram exercise (adapted from Chang, 2008). Completion of the culture gram highlights three primary identifiers and begins to paint a picture of who I am, the person at the heart of this process (see Appendix V). I have come to acknowledge three primary identities: caregiver, working class and teacher. This sharing of a personal story grates with my professional persona, and it may well be frowned upon within my community of practice where we generally hold firm boundaries between the personal and professional worlds. This discomfort is exacerbated, as, for the very first time in my professional life; I expose my working-class roots and the potentially associated shame (see Orbe, 2014). However, in the spirit of critical autoethnography it is necessary to embrace opportunities for self-interrogation which involve self-reflection, evaluation and analysis. This self-reflective introspection is bespattered with the formative experiences of ordinary, extraordinary, and seminal moments, showing the foundations of my current worldview and the works presented here. Short vignettes are utilised to capture real-time experiences and events which are influential in the story. These are presented in Appendix VI as *Stories from the Western Front*.

Given the highly personal nature of these narratives, some ethical consideration is warranted. In order to capture emerging ethical issues, a brief commentary is added at the end of each story. These commentaries, capturing ethical challenges, focus primarily on vulnerability and exposure along with the consequent steps undertaken to protect those involved. The literature on ethical sensitivity considered in chapter 2 provides a foundation for responding to these emerging ethical concerns.

Caregiver

In this mid-morning moment, I am transported to my mother's kitchen, remembering her response to Marty, a homeless man who travelled the roads of County Clare in the west of Ireland during the 1970's (see Appendix VI; Marty). My mother's simple philosophy was this:"when we give to people who are worse off than ourselves, we get it back a thousand times", or in biblical terms, "give, and it will be given to you…for with the measure you use it will be measured back to you" (Holy Bible, 2007). She did not try to change Marty and never judged him. Mam simply said: "he is entitled to live his life in whatever way he likes. He is a gentle kind man who harms nobody. He is living his life as he sees fit. He is a child of God like you and me. We are all struggling to survive. Let him go his own way". Mam had never heard of Carl Rogers, never studied person-centred psychology, and yet she had captured the essence of person-centeredness. She reached out to Marty and others from the core of her humanity, allowing them to live their lives in ways of their choosing. She placed the human relationship at the core of every encounter; she seemed to instinctively know what Koloroutis et. al., (2004, pp. 4-5) have written' that "a kind act...or through listening and seeking to understand the other's experience, a healing relationship is created". Her philosophy was congruent with the work of Miller and colleagues (2011) who present the German concept of *Menschenbild* which proposes that our belief in another's ability becomes a self-fulfilling prophecy. She was also espousing a philosophical position later described by Mearns and Thorne (2002) which argues that we all have significant internal resources and the ability to become all that we can be.

Marty died as he lived, on the side of the road in West Clare. A ragged journal in his belongings pondered his life, his friendships, and Susie's (my mam's) brown bread. He was happy, fulfilled, and living the dream as he saw it.

Meat was a scarce commodity in the west of Ireland in the 1970's, and the mealtime culture in our family centred on sharing our food and other resources (see Appendix VI; No Meat). We were all engaged in an elaborate dance of caring for each other. On the road where I grew up, people shared what they had and 'looked out' for each other. They worked together to make the best of their meagre resources. My mother referred to this as pulling together. They accepted themselves and others just as they were. They brought out the best in each other through laughter, joking, and the odd challenge (a dig as it was called). They sought to ease the pain of others. All ordinary working class, relatively uneducated people, my parents and their compatriots espoused an evocative philosophy later described and formalised by Bill Miller and others (Miller and Rollnick, 2013; Mearns and Thorne, 2007; Miller and Rollnick, 2002; Mearns and Thorne 2002; Miller and Rollnick, 1991; Miller 1983).

As I sit here in the mid-morning comfort of my home office, it would be easy to reflect through rose tinted glasses. The darkness of poverty, illness, and day-to-day struggles was bound to take its toll. Mam suffered what I now recognise as severe depression for much of her middle years, culminating in outpatient treatment at the local mental health services (see Appendix VI; Dark Days VI). Hindsight tells me that these formative experiences, this witnessing, contributed to a calling towards a caring profession. At 18 years of age, I entered training as a psychiatric nurse in one of the state's large psychiatric institutions. I grew up for the next three years in a mental hospital. It became my world. Psychiatric nursing served a dual purpose for me. I found that it allowed me to understand mental illness and offered a sense of control and autonomy in my life. I experienced the profession to be understanding and respecting of difference. Looking back, as an 18-year-old it was a crazy place. Staff, patients and families alike shared bizarre and unusual behaviour and thinking that put them outside the box that most of rural Ireland seemed to live in at the time. I liked thinking and living 'outside the box'. Although I saw great suffering, institutionalisation, and abandonment of society's most vulnerable (see Kelly, 2016), I loved the work; it became part of me; it got into my bones. I felt that I belonged, I was one of them.

That model of mental health service delivery was deeply flawed, and despite emerging government policy (Government of Ireland 1984), as a young nurse, I was devoid of an alternative map at the time. However, working with people experiencing mental health problems allowed me to fulfil my mother's prophecy. I realised that giving and receiving were two sides of the same coin. We nurture and are nourished by the act of reaching out from the core of our humanity to our fellow travellers. As I grow older, awareness emerges that my professional roles are indeed an extension of, and intimately connected to life experiences. As Rogers (1961, p 39) states "the therapeutic relationship is only a special instance of interpersonal relationships in general, and that the same lawfulness governs all such relationships". I now understand that the day I left home to commence my psychiatric nurse training, I had already been uploaded with a life programme imbued with aspirations to person-centeredness, underpinned by ordinary west of Ireland Christian principles and a longing to operate, to be, to live outside the square. I have recently come to reflect upon simple things, like my mother's proverbs: "he is a child of God", "let him go his own way", "when we give to those who have less than us we get it back a thousand times". I now appreciate how such family adages transmit subtle messages. These principles were built upon, tested, and strengthened through years working within the quirkiness of the Irish mental health services.

As I rehearse this story, I am conscious of the vulnerability of my family to exposure, which resonates with Ellis and colleagues (2011) concern of the heightened ethical challenges associated with writing autoethnographically about 'intimate others'. Chang's (2008) call to consider those other than ourselves who have rights in the story is worthy of consideration. I am also aware of my own vulnerability, and reminded of Tolich's (2010) analogy of autoethnographic writing to dressing in sandwich boards and 'proclaiming our stigma'. It is clear that I have responsibilities to my deceased parents, my sister, the homeless man, and indeed myself in this regard. Tolich's 'Ten Foundational Guidelines' (2010, pp. 1607-1608) covering consent, consultation, and vulnerability are instructive for ethical practice within this context (see Appendix III). To reach some resolution in relation to these dilemmas, I used pseudonym's (e.g. Marty) where appropriate, and consulted with my sister, affording her an opportunity to read

and consent to the use of this story. With the benefit of time and hindsight, I am satisfied that there were appropriate levels of self-disclosure. While telling and indeed celebrating the significance and potential of this most personal narrative, I strived to protect all those involved and at the same time not silence the story (Morse, 2002); a story that has laid the foundations for entering a caring profession; a story that sits at the very core of a dearly held person centred philosophy.

Working Class

My first recognition of discrimination emerged from an encounter with a new teacher where like Roberts (2014,) "...for the first time in my life I felt class..." (p. 56). Without fully understanding, I experienced what my mother later called 'class distinction' (see Appendix VI; New Class). Realising that I was treated differently to children from more affluent families, I came to understand that compared to them, I was deemed to be working-class. I learnt of the stigma associated with living in a low-income family and the analogous sense of embarrassment and failure. This shame is not easily shaken off and remains a constant in negotiating of my social identity. It is interesting that social progression and movement to middle-class living, to this day creates what Chang (2008) refers to as a 'fish out of water' experience (p. 74). Fortunately it also upsets my equilibrium sufficiently to fashion a more critical eye for issues of prejudice and discrimination.

Most of the lads from my kind of background during the 1980's ended up on the dole (unemployment benefit), labouring on building sites, in low paid jobs, or gone to America. Both of my parents had left school in their early teens, few in my family had successfully completed their leaving certificate (equivalent to A levels), and certainly, none had gone to college. I felt driven to do better, to get a proper education. I have often wondered what motivated such yearning. While my parents were not afforded opportunities for formal educational, the passion and enthusiasm embodied in their lived experiences significantly influenced my motivation for educational progression.

I belonged to a group known as 'first-generation college students'. My parents shaped my identity, not by what they said, but by what they did. Essentially, they lived their lives and allowed me to observe and participate in their journey. Every success in my career was marked in the local paper, my proud mother was my greatest supporter, cheerleader every step of the way. Psychiatric nursing, general nursing, higher diplomas, master's degrees, 'the best academic nurse 1989': all recorded for posterity in the annals of *The Clare Champion* newspaper. She was relentless in her support for my educational progression. Marian Edelman (1999) reflects upon such processes when discussing mentors in her life, in that they expressed no sense of limitation of her potential. In my case, mam was my first and most influential mentor. She created a philosophical foundation and fashioned a sense self-efficacy for all that followed.

The evidence relating to first-generation college students is stark. They are generally considered non-traditional (Chen, 2005), ill-prepared (Engle et al., 2003), socially disadvantaged (Lippert et al., 2005), high risk (see Roberts, 2014), and expected to drop out. MacLeod (2009) affirms the challenges inherent in aspirations for social progression, indicating that the social class into which one is born has a huge influence on where they end up in life. These stereotypes may well have defined me had it not been for an unquenchable ambition to do better, to be better. I saw education as my route to success. Payne (2003) affirms that education can be crucial to climbing the social ladder. In my case, professional training in nursing and subsequent achievements in college "provided...an opportunity to reinvent myself, understand my identity in a larger contextual frame and understand the socialising power of class" (Orbe, 2014, p. 201). It also offered a sense of control (Foster et al., 2005) which acted as an anchor in the choppy waters of late adolescence and early adulthood. A thirst for learning and an awareness of its ability to create freedom and opportunity have never been quenched; perhaps they are even insatiable.

As I write about people outside of my family, I am alerted to Clandinin and Connelly's (2000) questioning of our exclusive ownership of a story based upon our authorship. Within this particular story, as in most personal narrative, a significant character(s) emerges in my self-narration. The teacher who features in this story along with his/her family is potentially vulnerable to being seen in a negative light. In this case

it is necessary that I concern myself with the significant relational issues that arise (Trahar, 2009). In addressing such exposure, Ellis (2007) contends that the rights of those who have caused harm is 'not always' more important that the wellbeing of the author. Do my own negative experiences, my sense of injustice, give licence to cause harm to this person and his/her family? I contend that they do not. I am taken by the work of Tolich (2010) who highlights the need for clarity in separating our own personal experiences from the autoethnographic writing process. By way of protecting the teacher's identity, I avoided identifying gender, the specific school or timelines. During my formative years I attended several schools over a 13 year period and engaged with in excess of 40 teachers (many of whom fit the bill for this story!). Given the measures undertaken, I am confident that the teacher, his/her family and the school are not identifiable in, and not harmed by this story.

1 PM: Lunch is timely, as this journey of reminiscence, of going back to one's roots, is tiring, draining, and emotionally challenging.

Teacher

2 PM: I return from the rest and restoration of lunch with my wife Anne Marie to continue with this reflective journey. This time the spotlight of my attention turns to the role of teacher. While I spent my formative years working in the mental health services, I had always aspired to be a teacher, with the urge to teach never leaving me. I began to facilitate community drug education programmes in the mid-1990's in the working-class communities of West Dublin (see Appendix VI; Drugs Education). This culminated in the completion of a higher diploma and master's degree in adult and community education in the late 1990's. During this time, I embraced the work of those whom I later came to view as custodians of person-centred care (Miller and Rollnick, 2013; Mearns and Thorne, 2007; Miller and Rollnick, 2002; Mearns and Thorne, 2002; Miller and Rollnick, 1991; Rogers, 1961). Rogerian counselling and Miller and Rollnick's motivational interviewing challenged my professional identity by juxtaposing a traditional 'expert' care-giving role with a person-centred evocative philosophy. This person-centred philosophy, along with ideals of transformative learning changed me forever; I could never be the same; I could never go back. Teaching and learning became the cornerstones of my personal and professional identity.

As I engaged with communities in the processes of collaborative education, we all entered a new reflexive space where change and transformation became possible. Community members stepped up, confronted the state's bureaucracy, and challenged me to think outside the box, to reposition myself in a work context, to rethink my roles and theirs. In sharing transformative moments, we had begun to examine the state's tendency to shroud potentially sensitive social and political issues (Butler and Mayock, 2005). We were collaboratively engaging in adult education for transformation. Communities were attempting to shape their futures. I began to make a shift from enforcing the state's flawed policies to facilitating micro-change, all wrapped up in aspirations to change the world. From that time onwards, teaching was in my blood, my bones, and my very soul. While I have traversed long careers in nursing, counselling, psychotherapy, clinical supervision, and management (see Appendix VII and Appendix VIII), I find myself returning to the same place. Perhaps I love mental health nursing, get great satisfaction from counselling, am a competent supervisor, but essentially I AM A TEACHER.

Shining an ethical light on this narrative, I considered potential impacts upon the 'working class communities' referred to therein. Are they identifiable? Would they want to be identifiable? Would they now want to be identified as working class? I am reminded that when we write autoethnographically we do not exist in splendid isolation, so that we implicate other people in our work (Ellis, Adams and Bochner, 2011) or as Chang (2008) put it, we do well to remember that our research "...is never made in a vacuum..." (p. 69). I worked closely with these communities, I felt like one of them, and I am conscious that they are not "impersonal subjects to be mined for data" (Ellis, Adams and Bochner, 2011, p. 280). Taking on board Tolich's question "...who would be offended by what is written...?"(p. 1605) has been helpful in contemplating this dilemma. By attending to this issue in an ethically sensitive manner, I have been careful not to use overly emotive language; I have avoided criticising or speaking disrespectfully of the communities; and focused exclusively on what we had to learn together. Having worked in at least 15 working class communities through the 1990's and not naming the community specifically, I am confident that while illuminating my personal, socio-cultural and political learning, the specific community are not identifiable in, and not harmed by the story.

3 PM: Time for an afternoon tea break

Under the Rose Bush

Sitting in my wintery back garden, shrouded by Anne Marie's wild rambling, late flowering rose bush, I take stock and gather my thoughts. Reflection upon these identifiers of caregiver, working class, and teacher highlights many interesting insights. My professional philosophy, steeped in the rural west of Ireland of the 1970's and 1980's, was minted by parents who implicitly shaped my identity through the transmission of a whole set of social, cultural and personal values and expectations. The state psychiatric institutions of the 1980's and community drug services of the 1990's became the cornerstones of my professional formation. Caring in one way or another has become a central part of my identity in both my personal and professional worlds. Connecting with others in the journey of learning has become a key theme, if not an obsession, with teaching and learning permeating all aspects of my life. Person-centred principles have come to play a central role in my philosophical positions on teaching, caring, living, and learning. Ideals of education for transformation are key drivers of almost of all the activities in which I engage. My working-class roots in many ways help to ground me, offering an invitation to work for the disadvantaged, the marginalised, and the disenfranchised. They drive me to want better for myself, for clients, and for learners: the people that I purport to serve. These key social and cultural influences of my formative years provide constant background music for cognitive, emotional, and behavioural manoeuvrings within both personal and professional domains. This current reflexive journey highlights the need to recognise, embrace, and celebrate these life experiences, occurrences, and engagements which have ignited the fire of change and transformation in my belly. They are the intellectual, moral, emotional, social, and cultural struggles which form the crucible within which the works presented here were conceived and shaped, and within which they ultimately breathed life.

5 PM: Time for tea. This has been a long, exciting, challenging, and sometimes exhausting day. It is now time for rest and replenishment. I invite you to join me later this evening as we journey through the works, the contribution of which is submitted for consideration.

Chapter 4: An Evening with the Works

An Evening Stroll

6 PM: As tea time passes, with hunger satiated and in contemplative mode, I feel the weight of this work. I am becoming cognitively, emotionally, and physically exhausted. The journey thus far is taking its toll, and as the evening progresses, a walk in Kilkenny Castle Park becomes necessary. As I stroll by the river, my mind meanders to the contribution of the works presented in consideration for this doctoral award (see Appendix I). As we journey together, please allow me to highlight the principal contributions to policy and practice and locate the works within the socio-cultural context from which they emerged. I am now so familiar with these works that I can rehearse them step-by-step on my Castle Park walk. As many are co-developed, I must remember a declaration of authorship (see Appendix X). While it is important to outline my unique contribution for the purpose of this statement, it is essential to recognise that many of these works emerged from close collaborative endeavours. In my opinion, significant public works could and should never be designed by one person in splendid isolation.

A total of thirteen artefacts are presented for consideration in Appendix I. Detailed consideration is given to the SAOR (**S**upport, **A**sk & Assess, **O**ffer Assistance, **R**efer) model of Brief Intervention (Artefacts 1 - 4) and three mental health initiatives including CBT (Cognitive Behaviour Therapy) (Artefacts 5 - 8), Clinical Supervision (Artefacts 9 – 11), and Recovery College South East (Artefacts 12 – 13). These artefacts form part of a larger body of work which is listed as 'Other Works' (see Appendix I). As I step up the pace of my walk, I am transported in my mind's eye back to 2004.

SAOR Model

> ***Christmas 2004***
>
> Paul and I sit in the canteen at Waterford Regional Hospital, with the hustle and bustle, the comings and goings of nurses, doctors, and many others humming in the background. "There must be a better way of doing this", "I know, it's not working", "It's not us, it just doesn't fit", "it's not culturally appropriate", "the sequence is wrong", "there is no humanity in it". We had just voiced our shared critique of contemporary models of brief intervention for problem alcohol use. We agreed:

> "we will have to find another way". I took a red napkin from the Christmas stash and began to doodle on it. The SAOR Model was born. Rough, rudimentary, and an early prototype, this was our initial response to feedback from staff and clients that we had encountered on that part of our journey as clinicians and teachers of brief intervention. The napkin began to sketch, to envision, a model that was person-centred, culturally appropriate, and sequenced in a way that supported clients and hospital staff in utilising and engaging with brief interventions.
>
> (Journal entry, February 2014)

My work, along with colleagues, in developing the SAOR Model has its origins in the role of liaison psychiatric nurse/addiction counsellor in a major acute hospital in the early 2000s. Having identified deficits in contemporary models of Screening and Brief Intervention (SBI) for problem alcohol and drug use, I set about the task of devising an intervention model, which in my view was better sequenced, person-centred, and more culturally appropriate. The dominant model in use in Ireland at the time was FRAMES, which contained the key evidence-based elements of brief intervention (World Health Organization, 2003; Miller and Sanchez, 1994; Miller et al., 1993). This included giving the client **F**eedback, assigning **R**esponsibility for change to the client, offering **A**dvice, providing a **M**enu of change options, being **E**mphatic and supporting client **S**elf-efficacy. However, in my view as a clinician, it was poorly sequenced in that it commenced with feedback and offered no guidance on the relational dimension of brief intervention. Our early work led to a regional publication, *Dealing with Alcohol in Acute Care Settings,* in the mid-2000s (O'Shea and Goff, 2006). This progressed with the evolution of the SAOR model from 2006 onwards. SAOR is presented in two core publications (O'Shea et al., 2017; O'Shea and Goff, 2009) and a related guiding framework (HSE, 2012). The most recent 2017 publication locates the model within a policy context, offers a theoretical underpinning within brief intervention and Motivational Interviewing (MI) literature, and provides a robust step-by-step framework for delivery of SBI across a range of settings. SAOR has been adopted as the HSE (Health Service Executive) model of SBI for social inclusion and substance misuse services. It is now widely utilised in the training of workers in a diverse range of settings, with more than 4,500 frontline health and social care staff trained in the model. There are over 100 trainers currently involved in delivering SAOR training across Ireland. In a recent study utilising the SAOR model,

Armstrong and Barry (2014) tested the feasibility of SBI for problem alcohol use in emergency departments. Their findings state that "the SAOR model of training provided an appropriate training tool for introducing SBI to the emergency department and... feedback from the hospitals was positive" (p. 1). The GAA (Gaelic Athletic Association), Ireland's largest sporting and cultural organisation, has trained 900 coaches in the model. SAOR is integral to the association's ASAP (Alcohol and Substance Misuse Awareness Programme) and represents a key component of their 'Coaching with Confidence' programme. SAOR also forms the intervention component for their Prevention, Education and Response initiatives and is central to their Tobacco, Alcohol and Drug Policy and Guidelines. As a consequence of this process and associated activities, 800 GAA clubs now have tobacco, alcohol and drug policies. In a study of the impact of SAOR training with GAA coaches, Murphy (2013) reports that "training coaches to perform brief interventions for problematic alcohol use may be a productive exercise to reduce alcohol-related harm and promote health" (Murphy, 2013, p. vi). SAOR is also utilised in a broad range of other health, social care, and educational settings including: acute care, mental health services, child and family services, community-based drugs services, homeless agencies, primary care services, ante-natal services, third-level colleges, criminal justice settings, youth services, sporting organisations, health promotion projects, and social inclusion initiatives (O'Shea et al., 2017).

Development and dissemination of SAOR resources and training have, at all times, been located within the context of emerging policy developments in Irish health and social care sectors. Significant Irish policy drivers include (i) national substance misuse policy (Government of Ireland, 2017a; HSE, 2016; Government of Ireland, 2012;HSE, 2011; Government of Ireland, 2010; Government of Ireland, 2009; Government of Ireland, 2008), (ii) quality initiatives (HSE, 2017a; HIQA, 2012), (iii) mental health initiatives (MHC, 2008; Government of Ireland,2006), (iv) social inclusion policy (Government of Ireland, 2017b) and professional standards and guidelines (NMBI, 2015; NMBI, 2014; ICGP, 2014; ICGP, 2007; ICGP, 2006a; ICGP, 2006b). Developments have also occurred within the context of and been shaped by a number of seminal international policy drivers (EMCDDA, 2017; EMCDDA, 2016; EMCDDA, 2015; WHO, 2014; WHO, 2011; WHO, 2010). Motivational Interviewing theory and practice underpin

the core theoretical framework (Miller and Rollnick, 2013; Rollnick et al., 2008; Miller and Rollnick 2002). Other significant brief intervention publications from the UK have also influenced its evolution (e.g. Mc Cambridge and Jenkins, 2008; Heather et al., 1996). Web-based interventions were also considered (e.g. Linke et al., 2008; Wallace et al., 2006). However, the technology to deliver such online interventions was not available within the Irish health service at the time of development. SAOR has been influenced by a number of international brief intervention models offering step-by-step frameworks which are attractive to busy front-line workers. While we trialled the use of these models individually, they reviewed poorly with workers due to issues in the sequencing of interventions, lack of person-centeredness, and cultural difference. However, it was essential to draw upon these key theoretical constructs and practical frameworks. They are summarised below:

- NIAAA Framework (US Department of Health and Human Services, 2005).
- FRAMES Model (Miller and Sanchez 1994; Miller et al., 1993).
- WHO Manual - Brief Intervention for Hazardous and Harmful Drinking: A Manual for Use in Primary Care (WHO, 2001).

The SAOR project has not only responded to public policy but has in fact helped to shape numerous policy and practice initiatives since its inception. This includes (i) contributing to knowledge and learning on SBI, (ii) influencing policy developments, and (iii) shaping skills frameworks.

Contributing to knowledge and learning on SBI

While I have presented SAOR at numerous forums over the past nine years, two recent conference presentations of the model are significant. I recently presented SAOR at the plenary session of the international forum of Motivational Interviewing trainers which was hosted in Dublin in 2017.[1] This is the most significant annual learning and knowledge sharing event for motivational interviewing trainers internationally. The presentation and subsequent networking have generated considerable interest in the model. Conversations on collaboration are ongoing with colleagues abroad. In 2016 I presented SAOR at the Irish National Alcohol Conference. This represents the premier

[1]https://sites.google.com/site/minteventspage/forum-2017/download-forum-schedule

national forum for debate and discussion on alcohol-related issues here in Ireland.[2]This has led to significant and renewed debate about SBI across the alcohol field and helped to raise the profile of early intervention amongst service providers here in Ireland. Many initiatives are currently being explored within alcohol services, including the introduction of pre-treatment motivational enhancement programmes. These learning interactions add to and build upon our efforts in training several thousand frontline workers in the model over the past decade.

Influencing Policy Developments

SAOR became the first uniquely Irish framework for screening and brief Interventions with problem alcohol use in emergency departments and acute care settings back in 2009 (O'Shea and Goff, 2009; also see O'Shea et. al., 2017). Since then, it has continued to influence policies and developments right across the Irish substance misuse field. As outlined earlier, the model now provides the core SBI framework for the HSE Social Inclusion departments' national response to problem alcohol and substance use[3], and it forms the central plank of the GAA's national ASAP programme[4]. It also provides the core model for HSE, Office of Nursing & Midwifery Service Directors' (ONMSD) national *Guiding Framework for Education and Training in Screening and Brief Intervention for Problem Alcohol Use* (HSE, 2012). From 2010 onward, the model became the framework for the HSE's national transformation project on alcohol, *Towards a Framework for Implementing Evidence-Based Alcohol Interventions* (see Armstrong and Barry, 2014). Concerning drug rehabilitation, SAOR provides the SBI model for the implementation of the *National Drug Rehabilitation Framework* (Government of Ireland, 2010) and *National Drugs Rehabilitation Framework Protocols and Common Assessment Guidelines* (HSE, 2011). As brief interventions have become integrated into the national drug and alcohol reporting system, SAOR is now centrally located as a bona fide intervention within Irish alcohol and drug services.

[2]http://nwdrugtaskforce.ie/wp-content/uploads/2017/02/J-OShea-SAOR-Screening-Brief-Intervention-National-Alcohol-Conference-Oct16.pdf
[3]https://www.hse.ie/eng/about /who/primarycare/socialinclusion/about-social-inclusion/news/saor-screening-and-brief-intervention-for-problem-alcohol-and-substance-use-2nd-edition-.htm
[4]http://www.gaa.ie/my-gaa/community-and-health/gambling-alcohol-drug-education/saor

Shaping Skills Frameworks

In addition to the aforementioned contributions within the HSE and GAA, SAOR has provided the framework for the training of midwives on SBI in a pilot project addressing maternal alcohol consumption within ante-natal services in the north-west of Ireland as part of *Prescription for a Healthy Pregnancy Project* (Saolta, 2015). This project is expected to significantly influence alcohol interventions in other maternity services. The model now positions SBI at first point of contact for Traveller and Roma communities within the South East Community Health Care (akin to NHS community trust) in line with the *National Traveller and Roma Inclusion Strategy* (Government of Ireland, 2017b). It has also offered the basic framework for training of front-line workers across regional drug and alcohol taskforces (RDATF) for many years now. A recent off-shoot of this work has resulted in a collaborative initiative with mental health services, where a framework is in development for the training of workers in SBI within the intellectual disability sector (pilot training programme ongoing in North Dublin). SAOR also provides the primary model for training in SBI for the HSE's National Addiction Training Programme (NATP) and is included in the European Union Reducing Alcohol Related Harm (RARHA) Project Good Practice Toolkit (RARHA, 2016). This initiative has brought its reach to a European level.

When the SAOR journey began, there was no policy guidance for SBI within the Irish context. From the mid-2000s onwards, both Irish and international policy frameworks began to inform and underpin our work. In order to give credibility and robustness to the model, it was necessary to review the literature on SBI for harmful alcohol and substance use on a number of occasions over the years, the most recent of which is presented in the 2017 SAOR publication (O'Shea et al., 2017, pp. 20-28). The SAOR model has reached a level of influence within the Irish drug and alcohol field and beyond that neither my colleagues nor I ever anticipated. However, this widespread buy-in, loyalty to, and utilisation of the model is worthy of further consideration. This is explored in Chapters 5 and 6. Table 4.1 below maps SAOR publications to key policy timelines and related initiatives. Appendix IX highlights Irish and international policy developments and connects them with specific inputs and outcomes of the SAOR project.

Table 4.1: Timelines: SAOR Model Publications Mapped to Policy & Practice Initiatives

Irish Policy Developments			
2000- 2005	**2005 - 2010**	**2010 - 2015**	**2015 - 2020**
	• *National Substance Misuse Strategy: 2009–2016* (Government of Ireland, 2009) • *Report of the Implementation Group on Alcohol Misuse* (2008) • Irish College of General Practitioners (ICGP, 2014; ICGP, 2007; ICGP, 2006)	• *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives*, (Nursing & Midwifery Board of Ireland, 2014) • Irish College of General Practitioners (ICGP, 2014) • *National Standards for Safer Better Healthcare* (HIQA, 2012) • *Steering Group Report on a National Substance Misuse Strategy* (Government of Ireland,2012) • *National Drug Rehabilitation Framework* (Government of Ireland, 2011) • *National Drug Rehabilitation Framework Protocols and Common Assessment Guidelines* (Government of Ireland, 2011)	• *National Substance Misuse Strategy: 2017–2025* (Government of Ireland, 2017) • *National Traveller and Roma Inclusion Strategy 2017–2021* (Government of Ireland, 2017) • *Best Practice Guidance for Mental Health Services* (HSE, 2017) • *Clinical Guidelines on Opiate Substitution* (HSE, 2016) • *Connecting for Life, Ireland's National Strategy to Reduce Suicide 2015 to 2020* (Government of Ireland, 2015) • *The Scope of Nursing and Midwifery Practice Framework*, (Nursing & Midwifery Board of Ireland, 2015) • *Towards a Framework for Implementing Evidence-Based Alcohol Interventions* (Armstrong and Barry, 2014)
SAOR Publications			
2000- 2005	**2005 - 2010**	**2010 - 2015**	**2015 - 2020**
	SAOR 1st Edition (2009) ***Dealing with Alcohol Misuse in Acute Care Settings* (2006)**	***Guiding Framework Nursing & Midwifery* (2011)**	**SAOR 2nd Edition (2017)**
International Developments & Initiatives			
2000- 2005	**2005 - 2010**	**2010 - 2015**	**2015 - 2020**
• *Motivational Interviewing* (Miller and Rollnick, 2013; Miller and Rollnick, 2002) • *FRAMES Model* (World Health Organization, 2003; Miller and Sanchez, 1994; Miller et al., 1993) • WHO Manual - *Brief Intervention for Hazardous and Harmful Drinking: A Manual for Use in Primary Care*, WHO (WHO, 2001)	• *NIAAA Framework,* (US Department of Health and Human Services, 2005)	• *European Action Plan to Reduce the Harmful Use of Alcohol, 2012–2020,* (WHO, 2011) • *WHO Global Strategy to Reduce the Harmful Use of Alcohol,* (WHO, 2010**)**	• EMCDDA (European Monitoring Centre for Drugs and Drug Addiction), Ireland Profile (EMCDDA,2017) • *Emergency Department-based Brief Interventions for Individuals with Substance-Related Problems: A Review of Effectiveness.* EMCDDA papers, Luxembourg: Publications Office of the European Union (EMCDDA, 2016) • *The Role of Psychosocial Interventions in Drug Treatment*, [Online](EMCDDA, 2015) • WHO (2014)*Global Status Report on Alcohol and Health World Health Organization*(2011)European Action Plan to Reduce the Harmful Use of alcohol 2012–2020*, Copenhagen, WHO Regional Office for Europe* • World Health Organization Global Strategy to Reduce the Harmful Use of Alcohol, Geneva (WHO. 2010)

Mental Health Initiatives

7.30 PM*:* I have to admit to a significant level of satisfaction as I rehearse the scope and reach of the SAOR project. With the moonlight glistening on the river Nore, I sit for a while in the shadow of the former St. Canice's, the local mental hospital that served Kilkenny and its people over 150 years. My mind wanders back to projects that have supported the modernisation of our mental health service. Three such projects are worthy of further consideration. They include the development of national guidance frameworks in the areas of (i) Cognitive Behavioural Therapy (CBT) training, (ii) Clinical Supervision framework, and (iii) co-founding of Recovery College South East.

Cognitive Behavioural Therapy Training

My work in training mental health staff in CBT advanced significantly in 2008 when I led the development of a regional Cognitive Behavioural Skills for Practice programme (O'Shea, Goff and Gilespie, 2010). At that time, no such initiatives existed within the Irish health service. The impact of this programme on participants' knowledge and skills was evaluated in collaboration with Queens University Belfast, culminating in a peer-reviewed publication (Duffy, Gillespie and O'Shea, 2013) which concluded that "a short Cognitive Behavioural skills programme can enable mental health staff to integrate basic CB knowledge and skills into routine clinical practice" (p. 653). This publication facilitated the extension of the work to the national stage, which led to the development of a national guiding framework in Cognitive Behavioural Skills for Practice (HSE, 2013). This framework currently forms the basis for the training of nurses in basic CBT skills for day-to-day practice across the HSE nationally. Education based upon the framework is now delivered through a number of the HSE's regional centres for nursing and midwifery education (RCNMEs), and it influences the curricula of many third level colleges nationally, with two, in particular, having developed specific academic awards based upon this guidance. It is difficult to fully establish the number of participants who have completed education programmes based upon the framework. However, an exemplar from South East Community Healthcare (akin to a UK NHS community trust) is instructive. Back in 2009, there were no nurses trained in CBT with no training programme available in the region. There are currently in excess of 500 staff trained in basic CBT skills for practice as a consequence of the framework; 16 nurses have

progressed to qualify as CBT therapists (14 in mental health and 2 in primary care), and one of our early participants is now a Registered Advanced Nurse Practitioner (RANP) in CBT and leads the CBT Skills for Practice education programme across the whole of the South East of Ireland. The local third level institute offers both level 8 (degree level) and level 9 (master degree level) educational awards in CBT and psychosocial intervention. Many practitioners have trained in supervision and offer ongoing support for professional CBT practice to colleagues. This process has established a network for the development, delivery, and sustenance of CBT training and practice across the region.

CBT, which is a core part of contemporary mental health service provision, is recommended in international clinical guidelines (NICE 2009; NICE, 2004) with briefer and less specialised modalities widely used in England through the IAPT (**I**ncreasing **A**ccess to **P**sychological **T**herapies) programme (NHS, 2018; Richards and Suckling, 2009) and Northern Ireland within the *Psychological Therapies Strategy* (DHSSPS, 2009). No such policy platform on CBT or psychosocial intervention currently exists in the Republic of Ireland. However, emerging policy, legislation, and practice has facilitated the closing of former psychiatric hospitals and a concomitant move to community care, thus creating a need for more assertive community based psychosocial interventions (see Duffy, Gillespie and O'Shea, 2014; MHC, 2018; MHC, 2008; MHC, 2007; Government of Ireland, 2006; Government of Ireland, 2001). This, combined with guidelines within nursing pertaining to competence and scope of practice (NMBI, 2015;NMBI, 2014) and the evolving mental health recovery movement (HSE, 2018; HSE, 2017a; HSE, 2017b), creates the context within which the CBT skills training can develop. Given the relative policy vacuum, it was necessary back in 2009 to take risks in anticipating what might emerge in relation to CBT training based upon evidence from other countries (see Bennet-Levy et. al., 2009; Grey et. al., 2008; Roth and Pilling 2008; Trepka et. al., 2004). Policy and practice initiatives from other jurisdictions, especially the United Kingdom (UK) with which our health policy tends to be broadly aligned, were instructive. The aforementioned IAPT programme (Richards and Suckling, 2009; Department of Health, 2009) and the SPIRIT (**S**tructured **P**sychosocial **I**nte**R**ventions **I**n **T**eams) initiative (Williams, et al., 2011; Williams, 2009) are noteworthy in that they supported the widespread dissemination of brief CBT interventions and associated training programmes.

Brinksmanship

I stood near to the top of the boardroom table in the former psychiatric hospital in [town name omitted]. I was proposing the widespread training of mental health nurses in CBT across county [county name omitted]. The great and the good were present: clinical director, director of nursing, and all heads of discipline. I had done all of the background work, lobbying, negotiating, influencing – the lot! I had just made my pitch on a PowerPoint presentation. The tension was high: I was encroaching on the territory of others who considered therapy to be within their professional domain. The director of nursing and my friend [name omitted] stood at the top of the table and uttered: "I propose that we proceed with this initiative". There was dead silence; the tension was palpable. The clinical director, [name omitted] eventually stood up and said: "I am fully supportive of this initiative". That moment marked a watershed, a coming of age for mental health nurses in the South East of Ireland concerning being empowered to and fully embracing their role as clinicians and therapists within the mental health service.

(Journal entry, January 2010)

When I commenced the journey of developing guidance on CBT training, there was a consensus (if unwritten) within much of the Irish Mental Health Services that the nurse's role centred mainly on medication management and custodial care (see Cowman et al., 2001) with little involvement in psychosocial intervention. In fact, many of my colleagues from other professions at that time expressed concern that nurses utilising CBT may, in fact, harm service users. As it evolved, the project became as much about challenging existing professional paradigms and facilitating change as it did about CBT education per se. Consequently, it was essential to engage key stakeholders, including directors of nursing, psychiatrists, heads of discipline, nurse practice development coordinators, managers, budget holders, and other Health and Social Care Professionals (H&SOPs) in garnering support for the project. In particular, it was necessary to engage a psychiatrist in leading the early programmes in order to bring our medical colleagues on board. I also offered places on our training to colleagues from other professions who were afforded the opportunity to engage in skills development alongside 'nurses as equals'. Despite these initiatives, it took some years before our colleagues were comfortable with nurses practising CBT or teaching on the programme. Once we moved to the national stage, it was also necessary to engage the heads of

what was considered the gold standard CBT training schools in Ireland. Having the directors of Ireland's most prestigious CBT training programmes from Queens University Belfast and Trinity College Dublin on board facilitated me in engaging the ONMSD (Office of Nursing & Midwifery Services Director) to support the development of guidelines on the training of nurses in CBT. This ultimately led to the development of the national guiding framework: Certificate in Basic Cognitive Behavioural Skills for Practice (HSE, 2013) which, as outlined, forms the basis for CBT skills for practice training for nurses, and indeed many other health professionals across the Republic of Ireland. It is now standard practice that mental health nurses utilise CBT as part of their day-to-day clinical practice within the Irish mental health service. An increasing number now train as clinical specialists, advanced practitioners, and supervisors in CBT.

9 PM: As the day begins to die, I find myself wanting to keep going, to outline the lot, despite my waning energy. Please bear with me for a little while longer, as we journey through two further significant mental health initiatives.

Supervision Framework

Clinical Supervision has become progressively recognised as an essential aspect of modern, adequate health care delivery (Reiser and Milne, 2014; Milne, 2007). According to reviews in the UK, supervision is regarded as an essential resource for mental health nursing in England (Department of Health, 2006) and Scotland (Scottish Executive, 2010; 2006). This recognition is mirrored in international health policy (see Milne, 2007). Contemporary evidence suggests that adequate and appropriate clinical supervision plays a central role in the development of professional skills and competence, as well as reducing stress and burnout amongst our frontline clinical staff (see Gonge and Buus, 2015; Cookson et al., 2014; Wright, 2012; Rice et al., 2007). During early implementation of the CBT project between 2009 and 2014, it became clear that workers across our mental health service and mental health nurses, in particular, experienced significant challenges in accessing clinical supervision to support their professional practice. In response to this, I developed and led a regional education programme, *Introduction to Clinical Supervision*, which was approved by the Nursing and Midwifery Board of Ireland (NMBI). This ultimately became the HSE's national Introduction to Clinical Supervision training for mental health nurses. Through lobbying

and negotiation, I also brought the work in clinical supervision strategically to the national stage, where I co-led the development of a *Clinical Supervision Framework for Nurses Working in Mental Health Services* (HSE, 2015a). It is noteworthy that the said document was published hastily due to pressures of political expedience within the organisation. My view of such matters is in line with that of Robin Miller, (2015, p. 70) who suggests that "positive and visionary leadership is often thought to be a potential catalyst" for changing organisational culture. Thus, following persistent communication combined with significant negotiating and influencing, I was successful in receiving authorisation to lead the development of a more comprehensive national clinical supervision guidance document (HSE in progress). This work, which is currently in progress, has an expected publication date of the end of 2018. The new guide will enlighten a clear pathway for training in and delivery of clinical supervision across mental health nursing in Ireland.

When I commenced the process of promoting and developing clinical supervision initiatives back in 2014, there was limited policy guidance within mental health nursing in Ireland, with the exception of a recommendation in *A Vision for Psychiatric and Mental Health Nursing* (HSE, 2012) which proposed that all mental health nurses should have access to clinical supervision. While the vision document, along with previous publications (see PNA, 2008), mooted the value of supervision, they had not enlightened a path for its implementation. The HSE had also developed supervision guidelines for health and social care professionals during 2014-2015 without reference to or consultation with nurses (see HSE, 2015b). Despite the lack of engagement with nurses, that publication validated the role of supervision in "professional working life for an increasing number of the health and social care professions" (p. 3). In fact, it contributed to locating supervision strategically within a broader organisational context, adding credibility to initiatives that might promote the use of clinical supervision as a bona fide professional support for staff. Within a more general international milieu, a number of policy documents and initiatives from the UK, Australia, and Canada offer a contextual framework and practical guidance for the development of supervision initiatives here in Ireland (see Health Workforce Australia, 2011; HETI, 2011; NHS, 2011; NHS, 2010; Wiktorowicz et. al., 2010).

The process of progressing the roll out of clinical supervision and incorporating implementation strategies has advanced significantly in recent years. Once completed, the current guide will provide an evidence base and rationale, clear implementation strategies, and a policy direction for clinical supervision in mental health nursing across the Irish health service. As a consequence of this ongoing work, many community healthcare organisations nationally currently have working groups focusing on the implementation of clinical supervision within mental health nursing. Provision of support and guidance for this initiative has become a priority for the HSE nursing office (ONMSD) nationally. One related emerging initiative in the north east of Ireland is noteworthy in that it has extended the scope to provide peer supervision across all disciplines of nursing and midwifery services (HSE, 2017c). The key contribution of the supervision initiative relates to creating the first ever national framework for clinical supervision in mental health nursing and outlining a national standard for training therein. This is essential in supporting the enhanced role of mental health nurses in delivering psychosocial intervention, maintaining competence, and promoting their health and wellbeing within a complex and challenging work environment.

9.30 PM: As the last remnants of this day retreat into the darkness of a November night, I ask you to stay with me as we journey a little further. My mind rambles back to the sparks that illuminated our journey into recovery education:

Recovery College South East

Avoiding Clare

Due to my overloaded schedule, I was actively trying to avoid Clare who was attempting to establish a new recovery-focused education service in the south-east corner of Ireland. Eventually, she door-stepped me (for the third time!) and managed to give me a quick overview of her proposals. She anticipated a radically different way of engaging service users and their families: “we want to work more collaboratively”, “we want to put service users’ experience at the centre of our activities”, “we want to empower people to change their own lives”, “we want to offer alternatives to the dominant medical model”, “we want to help staff to see themselves and their clients differently”. “we need your help; we need someone on board who can build an educational rationale around it”, “we need someone who can shape it”, “we need someone who can help us navigate our way

> through the politics, who can help us access resources". I was hooked - person-centred, transformative and seeking to change the world. The only question left was: "How can I help"?
>
> (Journal entry, June 2016)

10 PM: As I return home with St Canice's falling into the middle distance, I begin to reflect upon how we currently engage with our service users. As the shadow of the asylum fades, radically new modalities emerge. That meeting with Clare marked the beginning of a journey which grows more exciting as the days pass. Recovery College South East was established in 2016, co-founded by Clare (current college co-ordinator) and myself. All College activities are governed by a college committee which I chair. We currently have five staff including the coordinator, peer educator, and three administrative staff. All initiatives are supported by Health Service Executive staff from mental health, social inclusion, and substance misuse services. We have gained significant support from national non-government organisations, including Carers Ireland and Mental Health Ireland, and some interest from the private sector. We have delivered co-produced recovery education to approximately 5,000 students since opening in 2016. The college is community facing, with hundreds of volunteers and students from all walks of life. The principal aim of the Recovery College South East is to provide recovery education programmes to people who experience mental health and substance-related challenges. People who access mental health, substance misuse, and social inclusion services are the primary audience; however, recovery courses are open to all, including professionals, volunteers, carers, supporters, friends, families, and the broader community. Courses are co-produced by people with lived experience of mental health and substance-related problems, professionals, families, and advocates. The college utilises an approach designed to develop people's strengths, talents, and personal resources (Recovery College South East, 2018). Our college website puts it thus:

> Recovery College South East will support people in developing their own recovery plans, in becoming experts in their own self-care, developing and growing peer support networks and encouraging people to learn from others who have faced mental health and or addiction challenges. (Recovery College South East, 2018, p 1)

This philosophy is mirrored by the national Advancing Recovery in Ireland (ARI) group who define recovery education in terms of facilitating "individuals, [to] explore, assimilate and create the knowledge required for recovery to occur in their own lives or in the lives of those they support or provide services to" (HSE, 2018, p. 2). Concepts of self-direction underpin this process by highlighting the value of lived experience, ownership of the recovery journey, hopefulness, and diversity (HSE, 2018, p. 2). We are one of four recovery colleges in the Republic of Ireland and the second to be established. We are, to our knowledge, the only mental health-based recovery college internationally that actively promotes the involvement of people experiencing substance-related problems. We have been successful in securing resources from and gaining the interest of the HSE nationally. HSE senior management recently paid a site visit as part of a process of engaging with innovative and transformative initiatives across our mental health service and acknowledging our role as innovative leaders within the service.

Reform of our mental health services with a move to community care set a necessary foundation for recovery-based care over the past decade and a half (see MHC, 2008; MHC, 2007; Government of Ireland, 2006; Government of Ireland, 2001). The subsequent evolution of collaborative approaches to mental health service provision established a clear policy context for recovery orientated initiatives (see HSE, 2018; HSE, 2017b; TCD, 2014; Government of Ireland, 2013; HSE, 2012; MHC, 2008). The Irish mental health recovery movement and subsequent educational initiatives owe their roots to similar initiatives in the UK (see Repper and Perkins, 2013) and internationally (MHC, Canada, 2015; Australian Health Ministry, 2013). From an Irish perspective, a recovery approach embraces four fundamental principles: (i) the centrality of the service user-lived experience, (ii) the co-production of recovery promoting services between all stakeholders, (iii) an organisational commitment to the development of recovery-oriented mental health services, and (iv) supporting recovery-oriented learning and practice across all stakeholder groups (HSE, 2017b).The latter point offers a clear context for the advancement of recovery colleges.

My role in the establishment and maintenance of the college relates to providing leadership, holding a transformative vision, strategically positioning the college and its activities, providing oversight/educational governance, and interfacing with key

stakeholders and supporters in promoting our activities, developments, and aspirations. In progressing the project, we have established collaborative partnerships with the RCNME (Regional Centre of Nursing & Midwifery Education) in the South-East and the local third level college (WIT or Waterford Institute of Technology), with both organisations represented on our college committee. In order to promote our approach and influence policy and practice within the fledgling recovery education movement in Ireland, it was necessary to gain a seat at the table of strategic national working groups. In 2016, I joined a national group with responsibility for developing a strategy for recovery colleges in Ireland. In 2017, I joined a working group charged with preparing a national recovery education guidance document to support the emerging *National Framework for Recovery in Mental Health* (HSE, 2017b). The recently published guide (HSE, 2018) is now central to the provision of recovery education across the Irish mental health service and in recovery colleges and beyond.

In Ireland we often say the 'proof is in the pudding' when it comes to the success of initiatives, pointing to the real or lived experience of those who avail of services. My 16-year-old son recently spent a week of work placement from school in our recovery college. His comments are instructive in highlighting the experience of those who attend on a daily basis:

> Adams Experience
>
> Dad, I was amazed when I arrived, the key was in the front door. Everyone let themselves in. When I went inside Mary offered me a scone. We all sat at the kitchen table and chatted. Everybody was equal. There was little difference between staff and students. I felt welcome and part of it. The courses were all developed and delivered by staff, families, and people who had used the mental health service. There was no mention of 'patients or clients'; everybody was simply a 'student'. It was very interactive, and they were interested in what we all had to say. It was challenging because we were expected to think for ourselves. As the morning went on, I changed my mind several times about the things we discussed. We all learned from each other. Imagine adults being interested in what I (a 16-year-old) had to say. It felt good, and I felt important and valued as a young person. I began to see myself, the other students, and mental health differently.
>
> (Journal entry, May 2018)

Students of Recovery College have also commented on their experience in course evaluations:

> Student 99
>
> I left school when I was in primary, didn't have very much of a family and I was always in trouble either with school or the cops. I have spent time in prison, and I haven't drunk (alcohol) in 14 months. I'm with Smart recovery, and I go to the meetings every week. The Recovery College came down and gave a talk at the workshops that anyone could attend. I came to the anxiety one and the recovery one. And they were grand ok, but I went to the emotion of anger workshop, and it was there it began to change for me. I couldn't believe that people were talking about anger, real anger and how it affects them...Recovery College accepts me the way I am and helps me to find better ways of living my life. I just finished the recovery educators training...and this was the only course I ever completed in my life. Since then I have signed up for (another) class because I know I can do it...I think that's what I got from the Recovery College.
>
> (Excerpt from Recovery College course evaluation, March 2018)

> Student 21
>
> I came to the anxiety course in Recovery College because I thought it would be good for me. It was. I have completed all the workshops now and am looking forward to the new timetable when it is out. It is nice to be a part of a workshop even with my disability, and I can use my ability, not my disability. Some of the students are like me, and others are very different, like the workers. We all have breaks and tea and scones together.
>
> (Excerpt from Recovery College course evaluation, October 2018)

There is little by way of traditional research evidence concerning outcomes for recovery education initiatives in Ireland at this time, primarily due to the novelty of the approach. There are some exceptions, with Agnes Higgins and colleagues reporting that "participants [were] very positive and enthusiastic about [the] programme and the benefits they had achieved personally and professionally as a result of participating"(Higgins et al., 2012, p. 2418).

We currently tend to rely on studies from other jurisdictions in supporting the development of conceptual frameworks and demonstrating the efficacy of recovery education (see Le Boutillier, 2011 et al.; Burgess et al., 2010; Institute of Medicine, 2006). Silver et al. (2011), reporting on the outcomes of a mental health education and

mentoring programme, indicate that both people in recovery and community volunteers demonstrated an increased understanding of recovery as a consequence of participation. Cook et al. (2012) in a controlled trial conclude that peer-led education improves participants 'self-perceived' recovery and hopefulness over time.

Organisational transformation lies at the heart of almost all modern mental health recovery initiatives, with an explicit intention to implant a culture and vision of recovery across the organisation. This incorporates (i) acknowledging, valuing, and learning from lived experience, (ii) building recovery orientated service partnerships, and (iii) developing a recovery orientation in the workforce (MHC Canada, 2015). Emerging practices tend to recognise and value the resilience and ability of people with mental health challenges. They also focus on autonomy, self-management and supporting family members in understanding both the challenges and opportunities which come from mental health and illness (Australian Health Ministry, 2013). These themes of organisational change and the consequent influence on practice are echoed within our Irish mental health recovery and recovery education frameworks (HSE, 2018; HSE, 2017b). To underpin our activities and contribute to the ongoing evolution of recovery colleges in Ireland, we are currently in discussion with our education partners on the commencement of a research project which will explore both the experiences and outcomes for students of the college. This will contribute to the body of knowledge on recovery education and support us in accessing the requisite resources to continue promoting transformative ideologies and practices within the Irish mental health service. The key contributions of Recovery College South East relate to initiating a collaborative, participative approach to recovery-based education in the south-east of Ireland and utilising our learning to promote transformation for our students and the broader organisation. This has required action at local, regional, and national level.

10.30 PM: Nearly there!

In a Nutshell

This chapter has outlined the contribution of the works presented for consideration in part fulfilment of the doctor of professional studies (DProf public works) at Middlesex University. It has highlighted the principal contributions to policy and practice and located the works within the socio-cultural context from whence they emerged. A total of thirteen artefacts are included (see Appendix I). Detailed consideration has been given to the SAOR model and three mental health initiatives including CBT training, Clinical Supervision, and Recovery College South East. By way of drawing it all together, the key contributions of the works are summarised below:

SAOR Model (Artefacts 1-4)

- Providing the preferred national framework for SBI across social inclusion and substance misuse services within the Irish health service.
- Underpinning the national framework for the delivery of SBI by nurses and midwives across the Irish health service.
- Creating the preferred national framework for responding to alcohol and substance-related issues for the GAA, Ireland's largest sporting and cultural organisation.
- Shaping the approach to SBI utilised within a broad range of health, social care, and educational institutions across Ireland.
- Contributing to overall knowledge and raising the profile of SBI within the Irish health and social care sectors.
- Influencing and shaping of policy developments relating to SBI in Ireland.
- Influencing and shaping of theoretical and skills frameworks on SBI across the Irish health and social care sectors.

Mental Health Initiatives (Artefacts 5 – 13)

- Providing the first regional and national frameworks for training nurses in CBT skills for practice across the Irish health service.
- Facilitating a turning point in the attitudes of mental health nurses, other professionals, and health service leaders relating to the role of nurses in utilising psychosocial intervention as part of their day-to-day clinical practice.

- Creating the first national framework for clinical supervision for mental health nurses in Ireland and outlining national standards for training therein.
- Initiating a collaborative, participative approach to recovery education across the south-east of Ireland and promoting the first mental health Recovery College internationally that embraces people with substance misuse challenges.

(see Appendix I)

10 PM: As the day winds down and having run out of cognitive, emotional, and physical energy, I realise that there is no time left for a critique of the works, no time for shining the light of critical autoethnography. In total exhaustion, I fear I must retire to my bed with a gnawing sense of unfinished business.

Chapter 5: Nocturnal Reflections

Good Night

10 PM: It is with a heavy heart and a sickening sense of disappointment that I retire to my leaba (bed). While my evening reflections of the previous chapter have outlined the contribution of the works to policy and practice and located them within the socio-cultural context from which they emerged, it is crucial to bring a more critical eye to proceedings. The promised appraisal of that contribution, utilising the lens of critical autoethnography, remains pending. With my best efforts to continue, and battling with exhaustion, I descend into the twilight world of sleep.

Darkness

My final thoughts as I fall into that much-needed slumber are disconcerting. In creating structured models and frameworks, I may well be accused of bowing to positivist and objectivist stances within my professional world. Critics may posit that despite avowed person-centred and transformative ideologies, these works still embody traditional theoretical perspectives which are arguably part of a dominant discourse within research and practice (see Mcilveen, 2008). I have to admit to a certain level of ambivalence with frameworks which, in my experience, can become double-headed monsters, with structure offering the warm glow of professional safety and comfort on the-one-hand and a terrifying sense of suffocation on the other. Scaife (2009) highlights this tension in her analysis that dominant models can "constrain rather than expand opportunities" (p. 25) while at the same time being "essential in helping...to structure... [our].. thinking" (Ibid.).

I wonder if perhaps the models and approaches hawked across our health service merely serve to maintain the status quo, covertly leading us to become trapped in what Carroll (2011c) refers to as situations where learning becomes "too dangerous" (p. 16). This may well lead to fear of "creating uncertainty or...putting us in conflict with those who would prefer us not to think for ourselves" (p. 17). As a consequence, we may assume conventional positions and take "conformist stances" (p. 17), where we experiment with novelty while concurrently clinging to agendas fashioned within dominant organisational discourses (O'Shea, 2014; Carroll, 2011). Weld (2012) discusses

such processes concerning clinical supervision where we can subvert its transformative function by focusing on managing risk, maintaining organisational conditions, and embracing “status quo conversation[s]” (p. 24). It is interesting to speculate on the extent to which our contemporary models and frameworks are risk-averse and supportive of the organisational status quo rather than seeking of change and transformation. I do not yet have a response to these questions, and perhaps the process of enquiry is as important as any answers that may emerge! Carroll's (2011c) advice is worthy of consideration where he invites us to “banish fear and shame and anything that threatens the fragile flower of learning” (p. 27), thus allowing us to “[sit] at the feet of [our] own experience and allow...that experience to become [our] teacher” (p .16).

Glimmer of light

It would be easy to sit back with a sense of satisfaction and fulfilment believing that the models and frameworks presented in Chapter 4 have changed the professional world within which I operate. It is therefore essential to bring a more critical eye to bear. Carroll (2011c) champions the "the ability to examine, to observe...to interrogate...to question...” (p. 19) and to “change the thinking behind [our] thinking” (p. 26). Within this analysis, we are invited to take an observer perspective, to understand the meaning-making processes of others and to subject our perspectives to critical review (Scaife, 2009). Mcilveen (2008) highlights the role of discourse in constructing reality within a milieu that explores both liberating and oppressive influences where we can be “avowedly transparent in the expression of [our own] values and personal concerns” (p. 15). There are of course multiple concurrent discourses here: the discourse within which the works were created, the voice of the works themselves, and the dialogue utilised to discuss emergent themes and consequent learning. They are all separate while interconnected conversations, occurring within different timelines and embodying varying levels of awareness. As we engage in these discussions, it is important to create a language that unsettles the ordinary and builds bridges between the personal, socio-cultural, and political domains (Holman-Jones, 2016, p. 228), thus attempting to become and embody the change that we seek in ourselves and the world. Despite the inherent discomfort in this process, it is important to untangle the lived

experience of developing and implementing these works with the benefit of retrospective critique. As a teacher, learner, and leader I am invited to gain fresh perspectives on what has been achieved. This has the potential to create a space where the exploration of the personal, professional, and socio-cultural can be bridged and even elevated to new and exciting levels. It is such a sad pity that the day is done! I am left with this confused muddle of uncertainties, questions, and half-answers.

In my final descent into sleep, I find myself dreaming of new ways, refreshing insights, and a new order. The work of Joe Griffin within the Human Givens Institute (2018) conceptualises dreams as "metaphorical translations of waking expectations" (p. 1). My consideration of these works may well be likened to a dream concocted of multiple scenes, and complex, sometimes confusing, metaphors. As I enter the land of nod, further insights begin to emerge. I invite you to journey with me as I recall my dreams: sometimes pedestrian, occasionally confusing, often insightful, and perhaps even transformative! Using a dream metaphor, I propose to engage with the works by way of elucidating 'key learning' that has emerged from their development and implementation.

Dreamland

That now familiar fullness of doctorate, context statement, and the public works looms strongly as I fall into a deep sleep. I am reminded of the words of Griffin on the function of dreams (Human Givens, 2018). He suggests that "expectations which cause emotional arousal that [if] not acted upon become [our] dreams during sleep" (p. 1). In this space of unresolved conflicts, confused insights, and half answered questions, I dream of open doors, brick walls, real people, pulling together, change, and stepping up. I invite you to reflect with me upon these dream fragments: scenes from my nocturnal journey, along with consideration of their potential thematic relevance for the works presented here.

> ***Open Doors***
>
> I walk through a narrow door with fixed head height. Considering my modest five-foot eight inches, I am surprised at the tight fit. As I step forward, I see multiple doors, all open, getting slightly more substantial as I progress: all well-lit with an airy feel. I seem more relaxed and know where I am going...

As the works progressed, it became apparent that the emergent models and frameworks appeared to offer a good fit for workers in that they could be easily integrated into existing skill sets. I realised that, in many ways, I was pushing on open doors in the advancement of the projects, and I wondered why. Feedback from those we trained in brief intervention, CBT, and clinical supervision over the years suggests that they found the approaches to be well sequenced, logical, and useful in their day-to-day practice, giving them confidence and a sense of competence in their work. This is confirmed in research arising from the works (see Duffy, Gillespie and O'Shea, 2014; Armstrong and Barry, 2014; Murphy, 2013). From the very beginning, we offered practical skills-based training and mentoring, with feedback suggesting that it increased workers' sense of role adequacy, role legitimacy, and role support in that they were more likely to take on roles and felt more competent and supported in doing so (see Loughran et al., 2010). I suspect that there were also deeper dynamics at play. It was as if the works spoke to something within their inner world, as if we spoke to their way of being. The works themselves were not capable of initiating action, but as workers interacted with them, a new dynamic emerged. Rather than merely offering something new, perhaps the works resonated with and awakened an inner knowing. Without full awareness, we had begun to evoke what people already knew. We were tapping into their internal wisdom and potential (see Miller and Rollnick, 2013). In resonating with their embodied knowing and creating a language that unsettled existing paradigms, perhaps we had begun to support them in connecting their personal, professional, and socio-cultural worlds (see Holman-Jones, 2016).

As a trainer, I have always been acutely aware that responding quickly to learner needs is essential if one is to remain relevant and be in a position to provide just-in-time learning, which meets workers' immediate concerns as they arise from practice (see Novak and Middendorf, 2004). Within this context, work related challenges presenting in the form of disorientating dilemmas become opportunities, creating an orientation towards learning and transformation of practice (see Mezirow, 2009). In my experience, the tension created in the mismatch between existing resources and one's expectations generates a level of anxiety which prompts one to seek out new learning. This was significant in the genesis of the supervision project, where a shortage of clinical supervision for nurses who were expanding their roles created a felt need for a

professional reflection and support forum. It was also apparent in positive engagement with the CBT skills for practice programme which emerged at a time when there was a desire amongst nurses to engage in the delivery of psychosocial interventions.

It was always important to remain aware of and responsive to contextual factors. Public policy and related practice initiatives created opportunities to use the works as vehicles in shaping clinical practice within the Irish health and social care sectors. Thus, it became equally important to offer frameworks and learning supports to organisations at the right time. I engaged with the GAA in the SAOR initiative after the O'Farrell publication identified significant levels of hazardous and harmful drinking amongst amateur sportspersons in Ireland (see O'Farrell et al., 2010). It is clear that in being attuned to GAA policymakers' concerns about the drinking habits of amateur sportspersons, we managed to locate the model at the heart of a major national organisation. We formally engaged with the HSE at a time when they were searching for strategies that would be supportive of the actions outlined within a number of national policy frameworks and developments (Armstrong and Barry, 2014; TCD, 2014; Government of Ireland, 2013; HSE, 2012; HSE, 2011; Government of Ireland, 2010; Government of Ireland, 2009; MHC, 2008). Thus, being able to feel the pulse of each organisation's policy and political needs became a central success indicator for the works. They were, it seems, delivered to the right people, in the right place at the right time, within an enabling political milieu.

As the work progressed, it was clear that if practice was to change significantly, then it was essential to continue engagement with practitioners and at the same time influence policymakers. It became necessary to have a seat at multiple policymaking tables, concurrently holding both 'insider' and 'outsider' perspectives: straddling the emic and the etic. This supported the integration of emerging works and helped to promote them within the field of professional practice. From the beginning, I realised that we would need to establish key strategic partnerships with those who could influence the development and integration of the works nationally. As a consequence, many key stakeholders within the health and social care world began to champion the models as evidence-based practical responses to policy and practice-based challenges.

There has been significant goodwill towards the works and associated initiatives over the years. This, in my opinion, has been influenced to a large extent by the provision of useful, user-friendly frameworks that have been offered rather than imposed. This has changed somewhat in recent years as the models have expanded nationally and become associated with the achievement of key performance indicators (KPI's) which has increased pressure to achieve measurable outputs, raising the potential for resistance. However, adherence to collaborative approaches that maximise motivation has reduced the potential conflict which often occurs in the implementation of change projects within the public service. This is evidenced in the SAOR initiative where the model's adherence to the spirit of Motivational Interviewing (MI) (Miller and Rollnick, 2013) made it attractive to workers and enhanced its credibility, as MI's collaborative approach is widely utilised and accepted in Ireland. All of the works, along with the associated resources and training programmes, were from the very beginning free of charge. We considered this to be important as, at all times, these were public service initiatives. We also thought it essential to share ownership of the models and frameworks, making them available to our community of practice to adapt and integrate as they saw fit. It is interesting to observe that the GAA feels SAOR is their model and the HSE's Social Inclusion believes it to be theirs. This relinquishing of power has, it seems, empowered others to utilise the works to their full potential, allowing momentum to build that, when combined with a spirit of collaboration, has brought the works well beyond the skills and abilities of any one person. A similar philosophy is prevalent in Alcoholics Anonymous (AA, 2001), where members are paradoxically empowered on their recovery journey by ceding power to the group or a higher power. Perhaps we were tapping into the wisdom of those who went before us, people who transformed their own lives with little or sometimes no professional input.

The fact that a range of international frameworks influence the works makes them applicable across multiple services. SAOR is utilised across a broad continuum, including prevention, early Intervention, referral to treatment, and harm reduction e.g. in line with Opioid Substitution Treatment (OST) guidelines (HSE, 2016). It has been utilised by those with harm reductionist philosophies as well as a precursor to abstinence-based treatment. Recovery College offers learning opportunities to people with mental health and substance misuse challenges and the broader community.

These philosophical positions, strategic decisions, and practical interventions have facilitated significant engagement with a broad community of practice and promoted the thriving and prospering of the works nationally. In progressing the projects, it was clear that not all doors would be open and that some may even be firmly closed. This journey of developing and promoting major public works has not been without significant challenges.

> ***Brick Walls***
>
> My dream becomes a little bit frightening. At the next door, I hit a brick wall. No way through. Nada. No light. I feel suffocated and experience a desire to run, to escape, to leave it all behind. I fear this is the end. The game is up, finished, done! I want to wake up from this nightmare. As I begin to retreat, I catch a tiny glimmer of light that illuminates a path, which although bumpy and winding, maps a route beyond the wall…

In progressing the works, we encountered many brick walls, seemingly never-ending winding roads and some mind-boggling bumps. Just as the first edition of SAOR was being published (O'Shea and Goff, 2009) and the CBT project was commencing (see O'Shea, Goff and Gilespie, 2010), Ireland entered the worst economic downturn since the 1930s. This led to reductions in health service budgets which had a significant impact on funding for new initiatives. Cutbacks in staff numbers, combined with a ban on all non-mandatory training during 2009/10, made it exceptionally challenging to progress training and development initiatives. Interestingly a corollary to these circumstances was that the public health service sought innovations, creating opportunities to progress the projects under a flag of ‘cost saving' and ‘transformation' initiatives. Portela and Thomas (2013) confirm this tendency towards decreasing healthcare expenditure during times of recession while acknowledging the potential for improved productivity and outcomes. However, when our health service began to emerge from the economic recession, there remained a significant lethargy and cynicism amongst frontline workers and managers alike. A level of ‘battle weariness' amongst key stakeholders has made it challenging to progress in new ways of working. This has slowed progress on the rollout and integration of learning initiatives, increasing the need to ‘sell' the concept of change to colleagues across the public health system.

Logistically it is challenging to provide training across the Irish health service, particularly in rural Ireland. Our services still tend to operate in silos often aligned to former health board structures (health boards were dissolved in 2005 and replaced by the HSE). This contributes to a lack of consistency in training provision at regional and local levels, with little or no significant workforce development structures in some areas. These logistical challenges were added to within the GAA with the majority of club and regional activities run by unpaid volunteers. This prompted creativity in sourcing 'tall poppies' or those who were highly motivated and prepared to integrate the works into their existing roles as well as leading and promoting them with others. It is notable that celebrating the contribution of high achievers within organisations is seen to promote success and reinforce cultural values. Participation in high profile national projects associated with the works may have acted as the proverbial 'slap on the back' for those who became involved, offering both opportunities for progression and acknowledgement of their contribution (see Claridge, 2018). Prototype E-learning programmes through Drugs.ie nationally, and the Cornmarket project in the south-east of Ireland significantly increased access to learning initiatives. The emerging HSELand (HSE E learning platform) national SAOR E-learning programme is expected to further address these logistical issues into 2019 and beyond.

Health service managers are faced with competing demands to release staff for mandatory training as well as a plethora of competing professional development courses. This frequently leads to aggressive competition for allocation of resources. We decided from the start not to engage in competitive or predatory practices in accessing resources or political profile and endeavoured not to become snared in other people's agendas; instead, we tried to give primacy to learning goals. Looking back, we were attempting to contribute to a learning and development culture which, according to Hawkins and Shohet (2012), is founded on three prongs: (i) creating a milieu and relationships within which people can learn about themselves, thus creating more options, (ii) professionals are better able to meet clients' needs when they are continually learning and growing themselves, and (iii) organisations that are learning themselves are far more likely to meet clients' needs. This was counter-cultural in many ways as traditional health service management structures are frequently competitive

and combative in their orientation. I always viewed the works as offerings which had developed their own integrity. This integrity was founded on promoting evidence-based models that were adaptable for practice, respectful to all involved, and progressed in the interest of those who availed of our health services. In explicitly embodying a respectful, collaborative approach, we hoped not just to advance the works, but to role model a way of being that, while sometimes counter-cultural, could facilitate useful learning within our community of practice. I have always believed that if the works were ‘useful enough', ‘good enough', and ‘offered respectfully', then workers would engage with them. This strategy has paid off in both the SAOR and Recovery College initiatives, with workers and volunteers coming in their thousands to attend learning and development initiatives.

The pressures of busy work schedules impacted heavily upon my colleagues and I, with all of us having busy full-time jobs during the development and dissemination of the works. Key challenges related to keeping a focus on policy developments, supporting working groups, and providing training programmes on multiple projects at the same time. It has at times been difficult to maintain the requisite life energy to give to this work, and this has undoubtedly impeded progress. The maintenance of passion and energy during the early years was essential to sustaining the projects to the point where external reinforcements arrived. Marshall Ganz (2010) offers interesting insights in his articulation that it is necessary to adapt to the rhythm of change in promoting transformation initiatives. These works have lived through and survived significant upheavals economically and organisationally, including Ireland's economic downturn and the reform of our health service. The survival and indeed thriving of the models was in no small measure connected to our ability to ‘ride out' the various storms, adapting and re-grouping when necessary. These challenges have been counter-balanced by the dedication and passion of all those involved, with many of the resource deficits being addressed in more recent times. The key learning here relates to the importance of ‘riding out' financial, ideological, and political storms when they arise, as the last person standing frequently becomes the champion!

An espoused philosophy of ‘putting them out there and letting the works speak for themselves' without holding on too tightly to ownership or franchise type arrangements has brought its challenges. It has contributed to practice related drift with some slippage in quality and not all trainers/practitioners who purport to be using the models doing so. The recent establishment of a national steering group led by the HSE Social Inclusion department will go a long way towards addressing quality assurance for the SAOR project, with similar steering groups now in place for Recovery College and clinical supervision. In my view, these groups while focusing on quality, would benefit from having a light touch on oversight, while concurrently remaining collaborative and responsive to the emerging needs of practitioners and clients alike. If we revert to failed hierarchical models, we risk squeezing the creative life and soul out of public works and those who utilise them.

As trainers and practitioners within the health service, we are well behind our academic colleagues regarding evaluating the efficacy of our work. With some exceptions (see Duffy, GIllispie and O'Shea, 2014; Armstrong and Barry, 2014; Murphy, 2013), there has been limited evaluation on implementation of the works. I recognise that rigorous peer-reviewed evaluation is required in this area if the projects are to retain credibility within the field of professional practice. The collection of data is essential in modern healthcare, and consequently, the introduction of KPI's for the delivery of training and the monitoring of national initiatives is welcome in that it addresses one aspect of evaluation (e.g. SAOR monitoring on national treatment reporting system). This will undoubtedly help to increase the overall profile and keep the projects on the national agenda. However, as we engage with an outcome driven health system, we run the risk of shifting the focus and indeed the perception of works from an offering to an imposition, creating the risk of transitioning from a place of passion to ‘box-ticking'. Adler (2012) explores the ambivalent feelings that staff frequently exhibit towards bureaucracy, experiencing it as both enabling and coercive at the same time. The potential for a sense of coercion to generate resistance is well rehearsed in the literature (Miller and Rollnick, 2013; Miller et al., 2011). While more robust data collection and tighter management of public initiatives may well be a necessary evil, I do hope that all those involved continue to hold the reins of power lightly, utilising methodologies that are in keeping with the spirit of the works. We must

be vigilant of the risk of invading what are essentially grassroots initiatives by outcome obsessed, bureaucratic structures which move us from collaboration to colonisation. We must remember that people, professionals, and clients alike lie at the heart of public works.

> ***Real People***
>
> As I continue my dream journey, I see people, hundreds maybe even thousands of people in my mind's eye. They appear healthy and contented. They look like they know where they are going, like they have an internal radar that guides them. Then I realise I am walking with them. I am one of these people.

Training in adult education, community development and counselling, along with my formative experiences (see Chapter 3) have undoubtedly spawned a person-centred philosophy which consistently lies at the core of the works. This is explicit in the first edition of SAOR (O'Shea and Goff, 2009) and further developed in the recent publication (O'Shea et al., 2017). We have always strived to hold a person-centred approach in the implementation of the projects. In working with a broad range of stakeholders, we kept the belief that all share a capacity to grow and fulfil their unique identities in working towards a transformation of their ideas and attitudes (Mearns and Thorne, 2002). These key person-centred principles (see O'Shea et al., 2017; Miller and Rollnick, 2013; Mearns and Thorne, 2007; Mearns and Thorne, 2002) in my view have supported workers in actualising their potential as trainers and practitioners (see Rogers, 1961). This desire to release innate capacity and to move towards fulfilling one's full potential (Mearns and Thorne, 2007; Mearns and Thorne, 2002) has in many ways brought out the best in all of us who have journeyed together. Conversely, this philosophical position also contributes to what some may consider a laissez-faire approach on my part, which has often led the projects to meander along rather than to progress in a focused manner. This has undoubtedly hindered progress, sometimes leaving my colleagues and collaborators seeking guidance when I was reluctant to be decisive. Perhaps, on the whole, this less than directive or gentle guiding style (see Miller and Rollnick, 2013) of mine has been a double-edged sword: on the-one-hand maximising participation, learning, and collaboration and on the other slowing progress and sometimes evading clear direction. The person-centred approach is not without its

critics, with Kensit (2010) suggesting that an eclectic approach may be more effective. Chantler (2004) argues that issues related to abuse, violence, racism, sexism, and power imbalance can be ignored, with the 'real world' often having a much darker side than this optimistic, positive approach may suggest. Han (2018) adds that in reality, we are generally not allowed to live in line with our internal guidance but instead adhere to established societal mores and guidelines. Despite these challenges, the collaborative efforts of workers and practitioners alike have fashioned significant progress in changing practice.

> ***Pulling Together***
>
> My dream flashes back to my mother's kitchen sometime in the late 1970's. Times are tough. My father has just lost his job, and belts would need to be tightened. Mam reminds my sister and me of the importance of co-operation. "We will need to pull together now, we are stronger together, and we'll get through this". All seems more comfortable once she utters these words. We all settle a little...

Central to a person-centred philosophy is the concept of collaboration. I have been strongly influenced within this domain by both person-centred and adult education ideologies. The collaborative spirit outlined by Miller and Rollnick (2013), which holds partnership and collaboration as central tenets, has influenced the evolution of the works and implementation strategies alike. Whilst I conceptualised some of the works (e.g. SAOR) as early as 2003, it was essential that other voices co-produce them. Hence, I have worked closely with my friends and co-authors (Ruth and Paul) and many others in bringing the models to their current incarnations. A collaborative approach brought the projects well beyond what I may have construed on my own and broadened all of our perspectives on what could be achieved. This spirit of reciprocity has led to the sharing of ownership of the works across a broad continuum of health, social care, and recreational settings. Cranton and Wright (2008), positing the notion of 'learning companions', highlight the importance of these symbiotic relationships on the learning journey, arguing that learners and educators become important people in each other's lives, with each enhancing the experience of the other. Taylor (2007) also highlights the seminal importance of reciprocal relationships in learning, suggesting that "through trustful relationships that allow individuals to have questioning discussions [and], share

information openly [we can] achieve mutual and consensual understanding" (p. 179). These perspectives are congruent with Mezirow's (2009, 1997, 1978a, 1978b) theory where engagement with others is construed as a central part of the transformative learning process.

> ***Change Change Change***
>
> As my dream journey ebbs on, things become more confusing, and nothing stays the same. Scenes flash by so quickly that I can hardly keep up with them. Everything looks different, colourful, and almost hallucinatory! It is terrifying, exciting and incomprehensible all at the same time. Change, change, change, all this change...

I have always held firmly to a principle of teaching for transformation by promoting methodologies that investigate "how adults learn to reason for themselves" (Mezirow, 2009, p. 23), encouraging all involved in interrogating their values, beliefs, feelings and judgements (Mezirow, 2009). Education programmes emerging from the works have endeavoured to support practitioners in embracing challenges and dilemmas as key opportunities for learning (Ibid.), thus potentially creating turning points (Foster et al., 2005, p. 9) for their practice. Workshops have encouraged trainers and practitioners to become critically reflective of their assumptions as well as to engage in discourse (Mezirow, 2009), thus creating opportunities for critical discussion, examination of evidence, and assessment of alternative positions (Sarver, 2012; Mezirow, 1997). This approach of teaching for transformation (see Mezirow, 2009; Freire, 2005; Brookfield, 1995; Mezirow, 1978a; Mezirow, 1978b; Freire, 1970) has facilitated all of us in becoming teachers and learners at the same time (Brookfield, 1995). It has not been without its challenges, as many of our trainers are accustomed to traditional organisational development programmes which often focus on the acquisition of skills and maintaining the status quo. If transformative ideals were to be pursued and we were to meet these challenges, I sensed that an extra push would be required.

> ***Stepping Up***
>
> A colossal step lies ahead of me, more significant than I have ever seen before. My dream becomes more frightening and confusing. Will I be able to step up? Will I slip? Will I fall, Do I want to go any further on this dream journey?...

I have always been a reluctant leader. However, the potential for the works to facilitate organisational change and challenge status quo thinking became key motivating factors for stepping up and taking on the mantle of leadership. I had to embrace characteristics like holding a vision, inspiring others, holding a focus on change, and enabling others to grow and develop (see Hiscock and Shuldham, 2008). Referring to the work of Cook and Leathhard (2004), Shaun Cardiff has described good leadership as an accumulation of five critical processes including (i) understanding the context and finding novel work practices, (ii) actively engaging with colleagues to challenge status quo thinking and practices, (iii) influencing others by sharing meaningful knowledge, (iv) identifying and responding to contextual signals, and (v) improving ownership of learning (Cardiff 2014; also see Cardiff et al. 2018). While some of these leadership characteristics seemed to emerge naturally, others required significant development, honing, and fine-tuning during the implementation of the works. It was essential to remain attuned to national priorities and respond accordingly (see Department of Health, 2004). At the same time, we were keen that the projects remain sustainable and avoid being trapped in a quagmire of 'quick fixes' that prevail across health services (see Hiscock and Shuldham, 2008). In addition to developing frameworks and models, it was important to foster more person-friendly ways of working which we hoped would contribute to increasing overall job satisfaction, reducing levels of staff stress, and retaining valued people (see McCormack et al., 2010). In holding a person-centred leadership space, we aspired to "fostering healthful relationships" between all stakeholders in a process underpinned by values of respect, autonomy, and mutual understanding (see McCormack et al., 2013, p. 193). This, in my view, is essential in developing fruitful professional relationships and the consequent delivery of both education programmes and services. It was also necessary to initiate support systems that facilitated workers in empowering themselves to ensure sustainability (Kane-Urrabazo, 2006) by taking ownership of the projects and progressing them within their field of practice.

At the time we were progressing the works, our health service was undergoing significant change. Along with responding to the aforementioned financial crisis, the organisation was attempting to make a cultural shift. This is notable in a recent corporate plan which commits to fostering a culture that is more honest, transparent, compassionate and accountable (HSE, 2015c). HSE values include care, compassion,

trust and learning. The Values in Action project focuses on building a culture within the health service that reflects espoused values in a way that makes them evident in the workplace (HSE, 2017d). In order to create traction, it became necessary to align closely with this cultural shift, as some of the works (e.g. SAOR) seemed a perfect fit regarding fostering person-centeredness, collaboration, and compassion in professional engagements. This alignment most certainly enabled progress at both the regional and national level, helping to further embed the works within organisational structures.

In reflecting upon the leadership skills and strategies outlined, it becomes clear that they resonate with contemporary literature. However, they were evoked by and emerged from practical challenges in the workplace rather than academic endeavours. The actual practice preceded any conscious awareness of relevant theoretical constructs. It seems that we learned to be leaders in the cut and thrust of influencing change within the Irish public health service. On this journey, I began to develop and hone my ability to network, build relationships, lobby, and lead initiatives. While I never had strong aspirations to engage in national leadership roles, I ended up spending nearly four and a half years leading national substance misuse and mental health initiatives. These roles created the opportunities, access and the credibility that were necessary to promote changes to practice in a diverse range of settings. For most of the journey, we did not adhere to stringent project management strategies with much progress ‘emerging' rather than being driven by rigid timelines and deadlines. This way of working is founded in the aforementioned dearly held person-centred philosophy that if we build strong relationships and trust with others, they will reach their full potential and become all that they can be (Mearns and Thorne, 2007). This is precisely what happened: people stepped up, took on the mantle, and pushed the initiatives forward within their areas of practice.

Hypnagogia

> In the twilight zone between sleeping and awakening, something begins to emerge in my mind’s eye. Vague and fuzzy initially, it seems familiar, maybe a report or a list. I arise from my slumber to jot down what I see...

3.30 AM: As early morning arrives, and my nocturnal journey begins to reach its end, I slowly awake from my dream. In the world between sleeping and waking, we sometimes enter what I have come to know as hypnagogia, a transitional state on our return to the waking world, a fuzzy place where one struggles for clarity. Following my dreamland reflections, many themes arise from the development and implementation of the works. My first instinct is to seek clarity, familiarity and order, so I compile a list of 'key learning' from the process. This is summarised in the widely accepted organisational practice of tabling and bullet pointing in table 5.1 below.

Table 5.1: Key Learning

Policy Context

• Two key factors are essential in locating public initiatives within a policy context. They include:
  o Identifying appropriate national and international policy drivers, and
  o Moving beyond slavish adherence to policy by becoming policy and practice influencers.

Practical Considerations
A number of practical issues are worthy of consideration when progressing major training and development initiatives within the public domain: • Frontline workers and volunteers in busy settings appreciate and respond well to the offering of step-by-step frameworks. • Skills-based training which addresses *role adequacy*, *role legitimacy,* and *role support* offer a useful approach in training front-line workers. • Geography and logistics present key challenges in the delivery of training, especially in rural Ireland. ELearning provides a partial solution to this problem; however, innovative solutions for attendance at skills-based training are also required. • It is useful to offer *just in time* learning when workers experience a felt need to learn or when they encounter practice related challenges and dilemmas. • Organisations, like individuals, respond well to new initiatives at times when they experience a felt need or perceive a crisis. These dilemmas offer opportunities for innovative learning and development initiatives at organisational level. • It is important that projects are adequately resourced from the beginning, as 'double

jobbing' by proponents/project leaders can slow progress and leave projects without adequate leadership and support.

- It is important to initiate support systems that facilitate workers in empowering themselves to take ownership of projects and progress them within their field of practice to promote engagement and ensure sustainability.
- It is important that learning and development projects have a broad appeal and avoid being *pigeonholed* into one particular philosophical tradition.

Contextual Awareness

- Contextual awareness should lie at the heart of learning initiatives within the public domain. This may include consideration of (i) the social, political, and historical context within which the work occurs, (ii) the policy drivers, (iii) organisational issues/dynamics, (iv) professional agendas, and (v) power relations; all of which may impact upon, influence, and the shape and direction of the works.

Teaching for Transformation

- Training initiatives would benefit from considering *teaching for transformation* where trainers and practitioners alike engage in discourse that promotes critical appraisal of organisational and professional issues and dynamics. This may include an examination of their assumptions, values, beliefs, and feelings along with a review of the evidence for their current positions. This essentially invites trainers to become teachers and learners at the same time, thus creating the potential to promote significant individual and organisational learning and allow for the emergence of alternative perspectives.

Contributing to Evidence

- 'Evidence' is highly valued within the health service. Within this context some key matters arise:
    - Rigorous peer-reviewed evaluation is required if major public service projects are to have integrity and establish/maintain credibility within the field of professional practice.
    - Research would best occur in a collaborative manner which includes frontline staff and service user participation in all aspects of the evaluative process
    - Organisations and practitioners alike would benefit from harvesting insights/learning directly from practice, thus producing practice-based

evidence.

Person-Centeredness and Collaboration

- The person-centred model has utility, not just as a therapeutic approach, but also as an underpinning philosophy for progressing major projects. This invites us to engage in practices that are underpinned by values of respect, autonomy, and mutual understanding. However, the risk of cloaking power imbalances, exclusion, professional elitism, and unhelpful organisational dynamics in the *soft* language of collaboration and partnership needs to be attended to.
- Within this inherently *less directive* approach, attention needs to be paid to maintaining focus, offering direction, and maintaining project timelines.
- Co-production of training to include co-planning, co-delivery, and co-evaluation with front-line workers and service users is worthy of consideration in developing relevant and meaningful training initiatives within a modern health service.
- A key success indicator for major projects involves seeking collaboration and freely sharing both ownership and resources with one's community of practice. This facilitates a process of moving from a place of *my* or *they* to the true experience of *us* and opens-up the possibility of collaborative and transformative learning to occur.

Organisational Issues

Organisational dynamics significantly influence the progress of major projects at both overt and covert levels. Several keys issues are pertinent within this domain:

- It is essential to remain intuitive to subtle organisational patterns and dynamics if one is to exploit opportunities for change and anticipate potential barriers as they arise.
- Change initiatives operate within the fabric of organisations; therefore, balance and good judgement on how much reflection and change can be tolerated are essential if resistance is to be reduced. This requires a highly attuned ‘organisational radar' combined with an adaptive leadership style.
- Being an organisational ‘insider' brings significant advantages concerning knowing the territory, but it may limit one's ability to see the bigger picture. Therefore, having input from people outside of the organisation may be helpful in navigating major initiatives through organisational structures and responding to emerging dynamics.
- Structured models and frameworks for practice have the potential to sustain positivist and objectivist stances within the professional domain by reinforcing existing paradigms

and dominant organisational discourses. It is therefore important to acknowledge that change and practice development within the public service arena occur within the context of contemporary social, professional, and organisational paradigms with inherent limitations and constraints.

Leadership Style

Some key leadership issues/characteristics are important in progressing major projects:

- Clear person-centred leadership has a utility in bringing stakeholders on board, tending to and maintaining relationships.
- Developing key strategic partnerships with those who can influence change is essential for the progress and ultimate success of major practice-based initiatives.
- Constant networking, lobbying, and influencing are critical success indicators for public service initiatives.
- Clear project management processes need to be in place; however, it is important to strike a balance between holding to project timelines and allowing for the natural 'emergence' that arises from the relational encounters/dynamics during implementation.
- A clear focus needs to be maintained on fidelity to proposed models, as widespread dissemination can lead to dilution in skills and theoretical drift.
- Resistance is reduced if new initiatives are provided as an *offering* rather than an *imposition*. Particular attention needs to be paid to this issue in an environment of Key Performance Indicators (KPI's) and tight outcome measures where workers may feel pressured to achieve certain performance measures. This has the potential to increase resistance and create a 'box-ticking' culture.
- It is necessary to market major projects/innovations to one's identified target audience, as competing demands, busy work schedules, and lethargy can become barriers to uptake and implementation within the public service.
- It is important to identify and affirm 'tall poppies' or people who are highly motivated and prepared to integrate the works and associated developments into their existing workloads and promote them to others.
- It is vital that health service leaders step up and take on the mantle of change. This may involve leading change at local, regional, and national levels.
- A number of essential leadership characteristics can support learning and development initiatives within the public domain. These include (i) having and holding a clear vision,

(ii) endeavouring to inspire others, (iii) holding a focus on change, (iv) enabling others to grow and develop, (v) promoting new work practices, (vi) challenging status quo thinking, (vii) sharing meaningful knowledge, (viii) identifying and responding appropriately to contextual signals, (ix) enhancing the sense of ownership and learning of others, and (x) remaining attuned to priorities at both national and local levels (see Cardiff et al., 2018; Cardiff 2014; Hiscock and Shuldham, 2008; Department of Health, 2004; Cook and Leathhard, 2004).
Battle Weariness
• Major external factors or shocks (e.g. economic issues) can have a significant impact on project progression. However, they can also act as catalysts for innovative and transformative ideas and initiatives. • Lethargy, cynicism, and 'battle weariness' are significant features of our public health service. This needs to be considered in project plans regarding its potential impact on participation in training and implementation of new models into practice.

3.55 AM: With my key learning is now harvested from these nocturnal reflections, I wonder, is that it?

Chapter 6: Awakening

Status Quo

4.00 am: Rehearsing the key learning in Chapter 5 surprises me somewhat, in that I appear to have gleaned far more practical learning from developing and implementing the works than I had expected. Just like many recurrent dreams, these initial considerations offer some familiar, if rudimentary, insights, bringing to light a 'how to' of progressing learning and development initiatives within the public domain. They do, however, appear to be somewhat banal and disconnected from the discourse of critical autoethnography proffered thus far. While they have significant value within my field of practice, they remain limited. It is clear they are located within a learning and development paradigm that is firmly grounded in traditional health service dogma, and that they pay scant attention to espoused transformative ideologies. One could reasonably argue that they remain pedestrian and somewhat dull, representing what might be considered a quasi-first level analysis, congruent with conventional discourses and status quo conversations. While they may well inform an organisational report, they fall well short of the bar set for this doctoral journey and my espoused ideals for transformative learning. This current role of doctoral researcher requires a more integrative culturally aware critique. It demands that I move beyond current clinical educational and developmental roles. Autoethnography can bridge this philosophical crevasse, inviting a new level of critique, understanding and action; one that unbalances and challenges established professional norms. As argued by Denzin (2017), we need to "... unsettle traditional concepts of what counts as research, [and]...expose and critique the forms of inequality and discrimination that operate in daily life" (p 8). This work must therefore embrace the promised reflexive stance; one that takes nothing for granted, tells a critical story, asks sometimes difficult questions, looks out to the world, is introspective, locates the public works within their socio-cultural-political context, explores power structures, embraces the creative, is emotional, welcomes personal transformation, and calls for social action.

It is clear that the works did not occur within a vacuum, instead emerging from a specific socio-cultural context. Key considerations include the lived experience of authors (see Chapter 3) and the gestation of the works within a large bureaucratic organisation in the midst of a significant economic crisis. All of us involved with the works belong to professional groupings: we are all western, white, and living middle-class lives regardless of our formative experiences. It would be fair to argue that we were, and continue to be, part of a dominant discourse (see Ellis, Adams and Bochner, 2011). It might well be argued that this is exemplified in the level of service user involvement in the evolution of the works. While we genuinely considered client feedback, there were no service users directly involved in early incarnations of the projects (with the exception of Recovery College), and there was limited research on client experiences (with the exception of second-hand accounts in Armstrong and Barry, 2014). While this is addressed in more recent iterations (see HSE in progress), service user involvement generally in the design, implementation, and evaluation of significant initiatives remains minimal, peripheral, and perhaps somewhat tokenistic within our health service. Whilst our notions of service user involvement have evolved, with significantly increased participation in the past decade, there remains a 'them' and 'us'. It could well be argued that as professionals we think that we know what our service users need, consulting sometimes superficially to seek their opinions. I wonder, though, what would we as professionals do if our service user 'representatives' disagreed, if they said the works were no good, if their utterance was that our pet projects would not meet their needs? Would we talk them down? Would we blind them with professional speak? Would we quote the 'evidence', or would we listen and respond honestly? These remain potentially terrifying questions because they shake the very foundations of the edifices that we construct in the name of our service users. Cotterell et al. (2010) explore this potential for tokenism, highlighting the need for robust research on service user involvement/experiences. Such research needs to delve well below the surface, asking the difficult questions and potentially eliciting responses that we *least want* but *most need* to hear.

The works discussed here were shaped by contemporary health policy which is a professional, middle-class endeavour and not always benign in its orientation or implementation. Butler and Mayock (2005) highlight a "...tactic of shrouding...policy in ambiguity...in the context of the wider tendency within Irish political culture to manage sensitive and potentially divisive social issues..." (p. 415). It would, therefore, be fair to argue that even with the highest aspirations to person-centeredness and transformative ideologies, the works still exist and operate within professional, social, and cultural contexts. If they have facilitated any modicum of change in the professional world within which I operate (and I believe that they have), then they have done so within the limitations and constraints of the contemporary social, professional, and organisational ideology which exists within and beyond our collective levels of awareness.

Despite an overall optimistic appraisal of the contribution of the works thus far, it is now necessary to explore the underbelly, to engage with the shadow of learning and development initiatives within an organisational context. What would it be like to move from the current level of thinking to a higher order? In the parlance of Bloom's taxonomy of learning, what would it be like to thread the insights from the works together in an alternative more creative way, thus generating novel ideas and new levels of awareness? (see Anderson and Krathwohl, 2001). This transition is in many ways akin to a birthing process: a struggling to emerge from the shackles of dominant forms of knowing, while at the same time frantically clinging to the structure, certainty, and security of old logic. It seems that another gear is required, perhaps even an awakening from a personal, professional, and socio-cultural trance.

Sitting Up

4.15 AM: As I return fully to the waking world, armed with my remembered dream fragments and my 'how to' list, some interesting insights begin to emerge. I now begin to view things through a different lens. My nocturnal journey slowly begins to make a little more sense. Emerging from this liminal space between sleeping and wakefulness, the words of a poem come back to me:

Magic Carpet

Tonight I was swept away on a magic carpet to a far, far away land.
I ambled through rugged foothills, tasted thin mountain air,
embraced an island paradise and bathed at the font of the Gods.
I sat by my father's chair, charmed, captivated and bedazzled by stories of Molly Wolly, Leaba Shioda and the good old days.
I heard the distant click of my mother's knitting needles and felt her loving embrace.
This was no ordinary dream but a voyage of fantasy, fun, truth and wisdom all bundled in the warmth of gentle friendship.
We shared stories of travel love hope dreams and aspirations.
We recounted trials tribulations and humble achievements – the balance, the gifts of life.
We stomped confidently down memory lane.
In that moment we were children running free, running wild – mates of the soul.
Tonight we were swept away on a magic carpet to a far, far away land.
We were home - home to ourselves, to our personhood, to the depth of our experience.
We knew deep inside that we had unearthed a different knowing, a nugget of wisdom,
a fragment of the eternal truth.

(in O'Shea, 2014)

Capturing the personal and the professional, *Magic Carpet* invites me into a different space: a place of clarity, openness, and reflexivity. A number of important themes arise from this awakening of mind. They relate to change and transformation: the way we do things, the imposter phenomenon, wrestling, command and control, and covering our asses.

Transformation Did You Say?

Despite a persistent and avowed commitment to transformative ideologies, the public works presented here pay scant attention to transformative processes. This is a surprising outcome of the work of a self-professed adult educator. Utilizing Carroll's (1996) tasks of supervision as a tool for self-appraisal, it becomes clear that the documented contributions put significant emphasis on administration, monitoring, and evaluation. It is interesting to observe that, while the teaching methodologies embraced transformative learning, the documents themselves remained largely conservative. Perhaps we became lost in checks, balances, and governance issues,

taking “conformist stances” (Carroll, 2011,p. 17) which led us to hedge our bets, play it safe, and remain confined to the narrow space which emanates from ‘status quo conversations’(see Weld, 2012, p. 24). The unwritten world of the teaching space allowed freedom of which the documents themselves were mostly devoid. The teaching environment became a safe place for the more radical, challenging conversations. It is interesting to notice that we ebbed and flowed between the status quo and what might be considered more incendiary learning spaces. It is of course important to acknowledge the humanness (Peseta, 2005) and frailty of the works. However as Bochner (2002) proposes it is also imperative that we contemporaneously question taken-for-granted uncritical projections, stories and preconceived notions of the self.

In reflecting upon my learning journey over the years, a pattern emerges, a trend which I suspect is shared by many of my colleagues within the health and social care world. Upon completion of master's degrees which held transformative ideologies at their core in 1998 and 2014 (O'Shea, 2014; O'Shea, 1998), I held the fire of change in my belly. A significant period spent working in community education in the 1990s nurtured that spirit. However, in the significant in-between spaces where I occupied more traditional roles, I appear to have retreated to the warm embrace of the training and development world: safe, secure, relatively conservative, and largely risk-averse. We are too often bound by invisible shackles that fetter creative potential, limit effectiveness, and quench the fire of transformation. Weld's (2012) propositions on the challenges of playing it safe, maintaining status quo conversations, and establishing rigid boundaries all hold true in these professional arenas. Combined with Carroll's (2011c) notion of taking conformist stances, avoidance of uncertainty, and pleasing those in authority, we often squeeze the living breath, the very life and soul, out of potential creativity and transformation. I am struck by how much one can collude with dominant discourses to keep the ship nice and steady, avoid the anxiety of radical change, and protect professional, personal, and organisational interests. I am even more intrigued by the blatant lack of awareness that frequently cloaks such conspiracies. We are often, it seems, devoid of a critical eye to cast on events. It is important then to take an honest look at the works; one that holds the self and culture together in a world of continuous fluctuation (see Holman-Jones, 2005). It is now time to untangle these issues with the benefit of a retrospective critique where there is an

opportunity to engage in the process of “chang[ing] the thinking behind [our] thinking” (Ibid., p. 26). Creating a space to gain fresh perspectives in a spirit of openness has, at the very least, potential to culminate in new, revised, and refreshing viewpoints of ourselves, our colleagues, and the organisations that we inhabit. This offers an opportunity to step out of the trance created by dominant personal, organisational, societal, and cultural experiences. It invites deeper understandings of interpersonal dynamics (Wyatt 2008), acts as a catalyst for taking my share of responsibility in events, enhances personal awareness, and facilitates personal growth and development, (see Kiegelmann, 2010; Goodall 2006).

The Way We Do Things Here

Warm engagements combined with a sense that the works are meaningful within the organisations ‘new order' (see HSE, 2017d; HSE, 2015c; HSE, 2015d) is most alluring. However, it is clear that, in many instances, espoused organisational values are in early gestation and often superficial, with a traditional bureaucracy forming the connecting “pattern that pervade[s] all aspects of...organisation[s]” (Hawkins and Smith, 2013, p. 10). It is, of course, also important to be cognisant of my own ‘insiderness', the extent to which I have weaved myself into the organisation's cultural fabric. Despite my desire for and protestations to objectivity, I was and am part of the organisational culture which I critique. I am acutely aware of Hawkins’s (2012) definition of culture when he refers to ‘what you stop noticing when you have worked somewhere for over three months’. I wonder what one stops noticing after more than 30 years? Hawkins and Smith's (2006) reference to levels of culture is instructive in that my colleagues and I were often operating to survive within and influence at various levels within the organisation's cultural infrastructure. The works created branded artefacts which became part of the organisation’s public offering, espoused a particular way of behaving in professional interactions, attempted to shift mindsets, influenced the way workers made meaning of their experience in professional encounters, and tried to motivate or promote change (see Hawkins and Smith, 2006).

In attempting to promote cultural shifts, it was necessary to innovate and challenge traditional paradigms. However, it was also important to operate within a defined territory that was acceptable to those in power, as stepping too far outside the

box can create unbearable tension, leading to overall rejection of proposals and proponents alike. In the UK, the Burdett Trust for Nursing (2006, p.24) highlights the importance of leaders having a sophisticated understanding of both organisational and political contexts combined with an adaptive style. Within this milieu, one's leadership style includes getting a feel for current circumstances and responding accordingly. Political astuteness relating to what ‘could' and ‘could not' be achieved became central in progressing the initiatives within the public system (see NHS Institute for Innovation and Improvement, 2006, p. 7). Transformative ideologies are of course counter-cultural, in that large organisations frequently prefer us to ‘sing the party’ line and not ‘rock the boat’. Holding these transformative ideas also raises ethical considerations. A good general does not lead his troops blindly into an ambush. Fuelling people's passion for change within a large bureaucratic organisation might do just that, as the system strives to maintain order. More in-depth reflection invites consideration of the responsibilities associated with holding what some may consider radical firebrand ideals. An awareness of potential negative cultural patterns and associated risks is warranted.

Attempts to facilitate organisational change go against the grain and are often resisted, sometimes fiercely. Hawkins and Shohet (2012) highlight some cultural dynamics which are incongruent with the processes of change and transformation. We have encountered all of these at some point along our journey. Organisations tend to hunt for personal pathology: they strive to fix problems and often banish those who they ‘cannot fix'. It was, therefore, necessary to minimise ‘rocking of the boat' to a point where the projects might have to be pathologised and rejected. We frequently flew below the radar of the organisation's vigilant bureaucratic culture, attempting to facilitate change without spooking the custodians of law and order. We strived not to get caught in the ‘watch your back’ culture where people avoided sharing information and covered their bases. We attempted to avoid being crisis-driven. As the works offered solutions to organisational problems, it was often a struggle to avoid being sucked into passing pangs of organisational anxiety for a quick fix. Navigating these organisational dynamics became a constant challenge with moderate success for the most part. However, the lure of familiar cultural patterns combined with the fear of challenging the status quo often led my colleagues and me back into a co-dependent relationship with organisations ‘addictive, sometimes compulsive drive to maintain

order, manage change, and maintain ‘control of the troops’ (see Hawkins and Shohet, 2012, pp. 229-234). An overly vigilant bureaucratic organisational culture can suffocate the developmental potential (Hawkins and Shohet, 2012) of public works, which may in turn be utilised as a means of controlling staff and ensuring that they operate within a defined space that maintains organisational homeostasis, control and power structures. We were sometimes (maybe often!) drawn by the allure of our large, dysfunctional organisational family’s warm embrace. One could reasonably argue that the works were colonising and at the same time being subjugated by organisational culture. They are to a significant extent a product of the culture within which they were conceptualised, forged, fashioned, and brought to life.

Imposter

Colonisation of a personal nature has emerged from what I call my own ‘imposter syndrome' (see Langford and Clance, 1993; Clance and Imes, 1978). Clance and Imes (1978) label this as “the psychological experience of believing that one's accomplishments came about not through genuine ability, but as a result of having been lucky, having worked harder than others” (p. 495). I have, on several occasions, found my co-authors and colleagues affirming the models and frameworks that I have created and lauding their success, while I simultaneously doubted myself, my abilities, and the process itself. This is undoubtedly linked to my upbringing and background (see Chapter 3). MacLeod's (2009) utterance that the social class into which we are born has a significant influence on where we end up in life offers a stark reminder of the limiting power of social class.

At the same time, I am sure that my background and identification with working-class values has in no small measure contributed to the works considered here, in that all of them seek to support people who may be excluded, struggling, or disadvantaged in some way. This was the likely inspiration, the *raison d'être* for progressing the works. A hunger for learning, a desire to right old wrongs, combined with an unquenchable passion for changing the professional world within which I live, have collectively driven me to develop a body of work that may never have emerged had I grown up within a more privileged environment. How lucky I am to have grown up in a working-class family! Adversity has in many ways become the source that fuels the work. I continue to

this day, even within my middle-class life, to embrace a working-class identity. While class has shaped the person that I am and many of the life choices that I have made, it has also limited my aspirations. Societal attitudes with or without intent can become introjected and may cause us to act out of the expectations of others within a vocational context. Gagné and Deci (2005) outline multiple factors within a framework of self-determination theory which may be utilised to conceptualise a broad array of both intrinsic and extrinsic factors that can motivate one within a work arena. Despite overtly disavowing traditional stereotypes and having an unquenchable ambition to progress, the more limiting shadows of my formative experiences are difficult to shed. This is a matter for critical reflection within personal development and supervision domains, and it requires ongoing attention if the works (and indeed myself) are to achieve their full potential into the future. It is crucial therefore to reflect upon "my identity in a larger contextual frame and understand the socialising power of class" (Orbe, 2014, p. 201) to better understand both the oppressive and liberating influences of my lived experience. The personal and professional are indeed inextricably linked. People, with all of their quirks, all of their frailties, and all of their fragilities, ultimately sit at the heart of public works, creating a tension which has the power to both restrain and transform.

Tensions

Throughout the process of writing this statement, I am acutely aware of multiple and complex tensions. I see them in the writing, which often experiments with the transformative and yet hints at the mundane and the bureaucratic. I see the flowery language of academia tempered with a lived experience of working for more than half my life within change-averse, hierarchical systems. Each time I hear the language of change, it is coloured with a hint of restraint. The person centred approach (Rogers 1961) of SAOR which locates knowledge, wisdom and the ability actualise innate potential, sits awkwardly beside CBT which remains substantially therapist led, vesting knowledge and 'objectivity' within the professional domain (Proctor, 2008). The evocative person centred ideology is also challenged by an autoethnographic stance which values co-production and calls for a broader social critique. Despite supervision's aspirations towards the transformative, organisational dynamics can radically constrain

its developmental potential (Hawkins and Shohet, 2012). The radical aspirations of recovery education may never be fully realised as they have largely failed internationally to gain a significant foothold within main stream mental health practice (Field and Reed, 2016).

The struggle between transformative ideology and deeply ingrained socio-cultural and professional patterns remains a constant. The lure of safety and comfort associated with positivist objectivist status quo thinking is continuously challenged by transformative ideology, as if the cognitive, rational self-were in conflict with the soul. My desire to fashion change is tempered with historical baggage and organisational realities. I am, it seems, an 'inside outsider' working within a politicised bureaucratic system where change is difficult to fashion. The 'insider' perspective facilitates what Foster (2005) refers to as the sharing of "...social and historical connections..." (p. 5) with others within the organisation. This emic perspective (Foster et al., 2005, p. 5), arising from the long personal experience of working in a system, offers valuable insights into many of the issues and challenges that occur on the journey (see Spiers, 2000). This undoubtedly has value regarding knowledge of organisational structures and processes, understanding the colloquiums, and promoting trust (see Foster et al., 2005; Leslie and McAllister, 2002).

A corollary of this relates to being 'one of the boys' with the inherent risk of failing to notice the oppressive influences of organisational dynamics. My insider perspectives, while insightful, are limited by the long-lived experience of working within the health sector. Many of these limitations which have been, and may well remain, beyond our level of awareness are subtly passed through generations of the professions akin to the transmission of family values where groups "transmit...and regulate...desirable and undesirable behaviours of [their] members" (Chang, 2008, p. 77). This was most notable in the subtle dance of creating works that would change practice and at the same time not alert the organisation's homeostatic mechanisms. It is entirely possible, and maybe even probable, that my fear based 'insiderness' prompting caution has limited the scope, depth, and potential reach of the works. It seems that 'insiderness' has become yet another double-edged sword, in that it offers a clear sense of how far the boundaries can be stretched and at the same time limits one's perspectives and aspirations. While significant organisational change has emerged from the works, one

could argue that a degree of relative homeostasis has also been maintained. Screpanti (2001) describes a process of conditioning that facilitates institutions in limiting and orientating people's aspirations and decisions. Such processes may well have shaped the works to a far more considerable extent than we ever anticipated.

Command and Control

Concerns of drift or a shift from established intervention practices and quality assurance processes became a burning issue as the works progressed (SAOR in particular). While we acknowledged the need for maintaining clear standards in training and dissemination of the works, a tension persisted. If we purported to bring the works as an 'offering' to our community of practice, surely we should hand them over without terms and conditions. Surely we should avoid bowing to the forces of 'command and control' (see Hawkins and Shohet, 2012). Davys and Beddoe (2010) describe a professional culture that is preoccupied with safety, risk, and cluttered checks and balances. Such frameworks tend to pervade our health service (see for example HSE, 2017; MHC, 2006). However, the challenge of practice related drift in brief interventions (see Pennsylvania Juvenile Justice, 2018) has been identified internationally in training and professional practice where the outcomes for clients deteriorate due to lack of rigour in training and mentoring of practitioners (see Miller and Rollnick, 2013). So perhaps it's more about balance: on the one hand we do not want to reproduce worn 'top-down' management approaches which clearly impede participation and engagement (Hawkins and Shohet, 2012), and at the same time we need to assure ourselves, potential funders, and the public that we can develop and maintain effective models of practice. A critical question that arises here of course is, whether we are doing this in the best interest of the people we serve or protecting our own professional interests and agendas.

*Covering Their Asse*s

My wondering as to why the works were so broadly acceptable draws me to a number of questions: was it because they met service needs, because they addressed skills

deficits, or possibly because they offered professional support? An alternative narrative might draw us back to the contention that, while the projects were change focused, they did not rock the boat too much; they operated within the organisation's tolerance zone for change and in so-doing ticked a change box while at the same time maintaining relative order. There were many times on the journey when we questioned our own and others' motivations for progressing in particular directions with the works. Some experiences in particular stand out in my memory in this regard. It is interesting to speculate upon the extent to which the SAOR project moved beyond a public health initiative to bridge socio-cultural and political domains. One could hypothesise that our work created political cover for a brewing political storm arising from the funding of the GAA by the drinks industry. One may speculate that we facilitated the GAA in being 'seen to do something' about problem drinking amongst amateur sports people. Within a historical context, SAOR, the Irish word for free, could be seen as manna from heaven for our largest sporting and cultural organisation with its roots firmly located in the fight for Irish independence of the last century. What a perfect battle-cry it would make for an organisation with a revolutionary gene pool needing to dodge accusations of collusion with the multi-national drinks industry?

HSE addiction services have historically been accused of focusing exclusively on drug treatment and placing limited emphasis on recovery. Keane, McAleenan and Barry (2014) have emphasised the importance of increasing the recovery orientation of HSE addiction services. SAOR may have 'ticked the right box' in offering a model with its origins in alcohol intervention (where a recovery focus is strong) and emphasising prevention/early intervention which is seen as a first step on the recovery journey. The world of psychiatric nursing was facing significant policy, logistical, financial and industrial relations challenges in providing clinical supervision in line with recommendations of *Vision* (HSE, 2012). The supervision programme offered relatively inexpensive, apolitical training that could quickly be delivered across the country utilising existing resources. Recovery College emerged at a time when the mental health services were accused of not being sufficiently recovery orientated, with the vernacular of traditional psychiatry becoming less acceptable to an increasing number of service users (Healthcare Commission, 2007). It is clear therefore that public offerings such as

the works presented here can offer both overt and unspoken incentives for proponents and supporters alike.

Such dynamics would undoubtedly offer opportunities to progress the works. A number of key questions arise here: In our efforts to facilitate changes in practice, did we collude with organisational efforts to evade the political ramifications of their inaction or perceived inaction? Were we complicit in letting them off the hook for their shortcomings? Did we take the King's Gold in order to progress our own agenda? And did the benefits outweigh the cost? Whilst there are no easy answers, there is a simple truth. In order to advance significant initiatives within the public arena, one has to make compromises both practically and ideologically and sometimes swim with the proverbial sharks. As we shine the light of critical autoethnography upon these processes, it surfaces professional and philosophical dynamics which previously resided beyond the edges of awareness. They undoubtedly merit further reflection and in particular raise the question of what would be done differently if we were to start over.

Next Time...

5 AM: As a new day dawns, I sit with a modicum of wakefulness and time to synthesise emerging insights. A number of areas for future development arise. If we were to start over, I would undoubtedly take a more critical stance relating to three aspects of the work in particular: developing practice-based evidence, utilising robust project management processes, and actively promoting transformative learning.

Practice-Based Evidence

A relative dearth of peer-reviewed evaluative publications arising from the works is undoubtedly an Achilles' heel. While the works have made significant inroads into the health, social care, and related sectors, their scope has remained national. Progression beyond Ireland would require further international peer-reviewed publication. Tingen et al., (2009) highlight the centrality of research and evidence-based practice within the nurse education arena: "it is critical that the...the nursing profession be exposed to, develop an appreciation for, and become more involved in...research, and thus incorporate its outcomes into the delivery of optimal...practice" (p. 170). Many factors have likely prompted the lack of such research. Subtle protectionist dynamics relating to securing the organisations 'intellectual property' lest they are criticised externally

often leaves public service initiatives here in Ireland with a low exposure to research. In the current instance, this is likely to be combined with the remnants of my own socio-cultural background and associated imposter phenomenon which surface the fear of the works being seen as 'not good enough'. It is clear that further progress will require an evaluative investment.

However, such inquiry requires innovative, critical approaches that challenge status quo thinking, surface both liberating and oppressive influences, and provide a lens through which new and alternative perspectives can emerge. The 'how' of any future evaluative processes relating to the works is critical if we are to avoid perpetuating traditional dogmas of research and practice. A challenge that arises then is how to re-author the story of public works in a way that mitigates the risks of making the same mistakes again. It is therefore important to tell and re-tell the story of public works. Ganz (2007) suggests that "as [we] go back to reconsider what went before, [we] may find it alters [the] story of now" (p. 4) leading to new perspectives and refreshing insights. Critical autoethnography offers potential as "an alternative method and form of writing" (Neville-Jan, 2003, p. 89) and a relational pursuit (Turner, 2013) that utilises personal accounts and draws upon the researcher's experience (Denshire, 2014) in re-authoring such stories. In placing ourselves at the centre of the research process, we may in Denzin's analysis "strip away the veneer of self-protection that comes with professional title and position... to make [ourselves] accountable and vulnerable" (Denzin, 2008, p. 137). Sally Denshire suggests that in so doing we can subvert the boundaries between our work and our personal worlds, thus breaching the perceived dichotomy between the self and others (Denshire, 2014). By crossing personal and professional spaces, we may begin to critique the works within a broader socio-cultural context (see Denshire, 2014). We may, in Brodkey's words come to see ourselves and colleagues as "human subjects constructed in a tangle of cultural, social, and historical situations" (Brodkey, 1996, p. 29 cited in Denshire 2014 p. 883). It is important of course that we "challenge...discourses dominant in [our] professional lives" (Denshire, 2014, p. 834) and endeavour to dissect the prevailing narratives, by "suggest[ing] alternatives and proffer[ing] viewpoints previously discarded as unhelpfully subjective" (Turner, 2013, p. 225). This may well assist us in challenging canonical ways of undertaking inquiry and necessitate any future research on the works to be political and

imbued with social awareness (Ellis, Adams and Bochner, 2011; Adams and Holman-Jones, 2008; also see SPRY, 2001).

Project Management

Another key concern arising from the development and dissemination of the works relates to project management processes. On a positive note, my colleagues and I actively embraced key leadership principles like holding a vision, inspiring others, and keeping a focus on change (see Hiscock and Shuldham, 2008): we developed good contextual awareness, challenged at least some status quo thinking, and enhanced others' ownership of the projects (see Cook and Leathhard, 2004); and we remained attuned to crucial priorities and continuously linked them with policy and organisational objectives (see Department of Health, 2004). However, while there was significant conceptual and skills development for both my colleagues and me during the process, the projects felt somewhat at sea from time-to-time, lacking clear direction and a hands-on project management approach. In holding a person-centred leadership space and endeavouring to foster relationships (see McCormack et al., 2013, p. 193), we may have disavowed many traditional project management processes. While our learning and development as leaders was emergent, rich, and imminently useful, we were most certainly learning on the hoof.

It is of course an imperative that project management processes within the public domain are congruent with the philosophy of any proposed models and not merely imported from the private sector (see Lannon and Walsh, 2016). Eversole suggests that although "a shift from top-down to more participatory models" gives people a voice, "real participation is often elusive" (Eversole, 2003, p. 781). Commenting upon the complexity of the social relationships which underlie major projects, Eversole urges that greater attention be given to "development relations" (p. 781). Within this context, a sense of agency, legitimacy, motivation and trust appear to support people in understanding and managing projects which incorporate complex social relationships (Campus Compact, 2015). Strang (2005) argues that those in leadership positions would do well to grasp transformational leadership in a way that underpins relationships and promotes associated organisational change. His research suggests that "effective team performance can result [from] minimal application of transformational leadership

behaviours" (p. 68). Barber and Warn (2005) propose giving significant attention to project progress in order to pre-empt difficulties rather than "just being reactive problem solvers" (p. 1032). Interestingly, the literature shows a dearth of research on project management style or competence as success indicators, while the general management literature is replete with such accounts (Turnerand Muller, 2005).

Combining insights from the literature with our existing experience of implementing major public works, a number of relevant project management issues arise. Dedicated resources are essential if adequate attention is to be given to the progress, processes, and outcomes of projects: collaborative models are required to maximise, engagement, and agency amongst all players; project managers would benefit from education and development on transformational leadership, incorporating co-operative approaches coupled with people-centred skills; projects should include full and active service user participation from the beginning; and project management processes should incorporate a sophisticated awareness of the personal, professional, organisational, political, and socio-cultural factors that impact upon project planning and implementation. Ultimately it is people, in relationship within a socio-cultural context, that deliver major projects. In hindsight, had these awareness and consequent processes been in place, smoother, more effective and more impactful dissemination and implementation of the works may have ensued.

Transforming the Transformative

As rehearsed earlier, while transformative ideologies have featured strongly in the educational programmes, they remain ill-defined and mostly absent from documentation relating to the works. Defining and clarifying these concepts would add significantly to future works regarding conceptualisation and the potential to facilitate individual, organisational, and cultural change. I may rightly be accused of over-reliance upon the work of Mezirow (2009; 1997; 1978a; 1978b). Other voices could be instructive in future considerations of transformative learning. They may include Sarver (2012) who presents an array of conceptual stances on transformative learning and Kitchenham (2008) who identifies a number of key underpinning theoretical perspectives, including the work of Kuhn on paradigms, Freire on conscientization, and Habermas on domains of learning (see Kitchenham, 2008).

This diverse range of approaches creates a rich tapestry of conceptual and theoretical frameworks, guiding the development of adult learning across cognitive, social, political, spiritual, and ethnic planes (Sarver, 2012). They traverse the fields of health and human sciences, moving us from unitary concepts of learners as individuals to systemic perspectives which view people as interconnected bio-psychosocial beings. These sundry ways of knowing would contribute significantly to the ongoing development of the works, bringing them to more in-depth, more vibrant, and more inclusive levels. In reality, transformative learning includes coming to see the world from more diverse and open points of view. The lenses through which one views the world and oneself may be psychological, social, cultural, political or economic. Seeing the world through "multiple and varied lenses" may offer more "informed and more inclusive perspective[s]" (Sarver, 2012, p. 329), thus advancing the transformative dimension of future works and the systems they purport to influence (see Laurence and Cranton, 2009).

Those of us who assert to be adult educators frequently treat transformative learning as the Holy Grail: infallible and incontestable. Newman (2012), in a self-proclaimed *mutinous* contribution, offers a less than benevolent analysis, identifying "flaws that commonly occur in explanations of transformative learning" (p. 36). His disagreement focuses on a number of areas: the notion that transformative learning differs from other learning in kind rather than degree; the failure to make a clear distinction between identity and consciousness; the assumption that learning can be a finite experience; issues relating to the conditions of *empathy* and *willingness to seek understanding*; and the possibility that mobilisation is mistaken for transformation (Newman, 2012, p. 46). Newman's somewhat reductionist perspective would seem to favour scientific enquiry which emphasises objective, quantifiable data-driven outcomes. Such a scientific paradigm looms in stark opposition to the more qualitative learner centred measures located within lived experience which value people's self-perceived, subjective experiences of change and transformation. While Newman's proposition carries more than a modicum of cynicism**,** it does highlight the need for healthy critical debate on what is often considered an *unquestionable given* in the field of adult learning. Kucukaydin and Cranton (2013) support this call for critical reflection, suggesting that "while celebrating the development of transformative learning as a

theory in progress, we...should not stop critically examining current developments" (p. 53). In a comprehensive review of available studies, Taylor (1998) highlights the need for research to consider context and catalysts for transformative learning, the importance of alternative perspectives, and the value of relationships in learning. By gathering these conceptual frameworks and critical conversations together, we may better inform the future development of public works. A key challenge relates to integrating transformative ideologies and methodologies into the heart of public works from the beginning rather than having them as add-on's or attempting to fly them under the organisation's political radar. Essentially, we need to locate transformative ideologies at the core of public works, making them explicit and acting upon them from the very beginning. We need to understand learning as it is lived in people's lives. Significant learning may only be transformative to us in hindsight. Moving beyond traditional paradigms allows us to capture moments of awareness, epiphanies that are arguably far more important than some of our contemporaneous sterile output and outcome measures. If we are to truly learn from our public works, then a gear shift is required, a move that brings us into a more reflexive space, a movement beyond our reflexive edge.

Drawing the Threads Together

5.30 AM: In this November morning's pre-dawn rummaging, a significant amount of clarity has emerged from consideration of the works in my dreaming state. This chapter has exposed the contribution of the public works to the lens of critical autoethnography, utilising a deeper reflective process and surfacing further insights. Consideration is given to what might be done differently in the future. Emergent insights highlight significant learning from the development and implementation of public works. As well as making a very substantial contribution to my own learning, I trust that this offers guidance to colleagues who may undertake similar initiatives in the future. Drawing from the previous chapters, fundamental contributions of the works may be considered at two levels: what one notices at *first glance,* and what emerges from a *second look,* upon awakening from a personal, socio-cultural, and political slumber. Chapter 7 summates these revealing glances.

Chapter 7: New Dawn

Beginning Again

6 AM: As a new day begins to unfold, I am aware that we have gone slightly over our proposed twenty-four-hour timeframe, something that grates uncomfortably with my traditional health service training and professional identity. However, I am also conscious that important conversations cannot be packaged so neatly. As our journey continues, it is time to summate the contribution of the public works presented here. In this context statement, I have considered the key contributions at two levels: what one notices at *first glance,* and what emerges from a *second look.*

At a First Glance

The works themselves provided scaffolding for the professional development of front-line workers within a range of health, social care, and recreational settings. Designed to be practical, step-by-step and accessible, it appears they have resonated strongly with participants and called forth their existing skills and abilities, connecting perhaps with their inner knowing. The emergent models provided professional frameworks across Ireland's largest statutory, voluntary, sports, and cultural organisations. Within these contexts, the works helped to shape policy and practice across a range of mental health learning initiatives including SBI, CBT, Clinical Supervision, and Recovery Education.

Further consideration reveals a number of contributions and learning's emerging from the implementation process. These include highlighting the importance of connecting projects to the policy context while contemporaneously seeking to shape policy, offering practical tips and tools for project management, valuing the transformative dimension of learning, creating practice-based evidence, promoting person-centred care, addressing organisational and political issues, and overcoming practical implementation challenges. In hindsight, the process of progressing the works became as important as the works themselves. Central to this was the person-centred approach, which, while explicit in some of the works (e.g. SAOR), became intricately interwoven into the fabric of implementation processes. Treating people with respect, along with acknowledging and valuing the uniqueness of individuals and groups, was central to our philosophy. As we progressed the works, the language of collaboration

and partnership became everyday speak across the projects. Holding hope and a vision for the potential of every person and attempting to release their inner wisdom was counter-cultural within bureaucratic, hierarchical systems. As we continued, those involved increasingly articulated and embodied person-centred principles. It seems that we were role-modelling a different way of being within the public domain. In the process, we learned to be leaders, honing and fine-tuning our skills and sharing them with others. Significant emergent leadership characteristics include: having and holding a clear vision, inspiring others, focusing on change, supporting growth and development, transforming work practices, challenging the status quo, identifying and responding to contextual signals, enhancing a sense of ownership and learning for others, and remaining attuned to complex priorities at local, regional, and national levels.

A Second Look

A second look invites a more critical eye, an awakening, and a shift from the banal and the mundane. This is somewhat akin to shifting from a position of trudging through forest undergrowth to floating aloft the treetops: a helicopter view per se. Reflection upon the lived experience of developing and implementing the works suggests that, however benign in their aspirations, public initiatives are never apolitical; instead they often serve needs well beyond their stated aims and objectives. While many of us who work within the public service hold transformative ideologies at our core, these are shaped, moderated, and moulded by life experience, organisational dynamics, and social and cultural issues. Our complicity in progressing covert organisational agendas often remains unprocessed and beyond our levels of awareness. Proponents of significant public initiatives are generally insiders who are inextricably woven into organisational life. Whilst challenging the system, we rarely unsettle the status quo to any considerable extent, with published works often serving as artefacts of organisational identity. While preaching radical ideology, we may well remain compliant with an organisational ‘command and control' infrastructure.

It is clear that the personal and professional are inextricably linked, with lived experience and socio-economic background significantly influencing one's present-day professional interactions. Class background may act as the spark that enlightens the fire of transformation and at the same time limits one's hopes, aspirations, and the potential of consequent works. This may contribute to significant tension as one straddles the *emic* and *etic*, the thrashings of the *inside outsider*. It is as if we embrace multiple personalities: we may be radical in our academic writing and classroom encounters, yet custodians of organisational order in the 'real world'. Covert cultural patterns and dynamics serve to maintain order and retain status quo thinking. Moving beyond these unspoken parameters may well create anxiety and fear of alienation, a risk that many of us are bashful in taking. In my own experience, a desire to fit in, to be part of the order, can lead to the taking of conformist stances and quietening of the transformative voice.

Epilogue

6 AM: Appraising the contribution of this diverse range of public works has called forth a more contemplative stance; one that contextualised each of the works, created and demanded a different kind of investigation; a transformative inquiry that invited reform of the professional world; one that moved beyond traditional scientific inquiry to straddle the personal, social, cultural, and political worlds; Drawing upon artefacts, storytelling, poetry and journaling this context statement highlights and affirms the contribution of a body of public works to my field of professional practice. As well as making a significant contribution to my own learning, this statement provides a clear methodological path for colleagues undertaking similar initiatives in the future. While I initially sought to highlight the import of these previously published works, it has taken me far beyond initial aspirations, bringing to the surface a whole raft of learning relating to the socio-cultural and organisational dynamics which arise in the process of implementing learning and development initiatives within the Irish health service. It has fostered much self-observation, taken nothing for granted, asked difficult questions, looked outward, 'bent back' on the self, located the public works within their socio-cultural-political context, explored power structures, embraced the creative, welcomed

emotion, invited personal transformation, and called for action; It has become both contemplative and reflexive.

As I reflect upon the dynamics of utilising learning and development initiatives to facilitate change and transformation within the world of professional practice, I wonder whose reality really counts and whose needs are met by our public offerings. We profess transformative ideology, but what does that mean? Are we prepared to explore the shadows and the deficits of transformative learning? We profess to work in the best interest of our clients and service users, and yet it is entirely possible that our offerings serve as sticking plasters, soothing our collective shortcomings. Perhaps we are complicit in unspoken conspiracies to cover up real or imagined, personal, professional, or organisational limitations. I still wonder how much further we could have pushed out the boat of change and transformation. How much more genuine service user involvement could we have fostered? How much more could we have transformed practice? How far outside the box could we have gone before triggering organisational homeostatic alarm bells? How far could we have travelled before stalling for fear of losing control? How much more insight could we have gleaned from the process?

This barrage of questions may, of course, be overwhelming for *inside outsiders* like me. Adele Clarke's (2018; 2005) work on situational analysis offers a structured process of inquiry, providing *situational*, *social world,* and *positional* maps. Mathar (2008) posits that such maps offer a means of better understanding the contexts which "represent the...messiness, contradictions and heterogeneities" (p. 4) of our social word. Chang's (2008) work on culture grams may also be utilised to bring order to the messiness of these multiple and complex forces which can impede or promote transformation and change. Perhaps we rarely ask ourselves the difficult questions, the inquiries that we fear as we sit within the comfort of our middle class professional worlds. Maybe it's not so much about the questions and answers, perhaps the real learning lies in the *in-between*, the space amidst the questioning and answering, the reflective space where we take a second look. This is where perhaps, we can bring a critical eye to our taken for granted assumptions, interrogate our lived experience and expose our broken models. Maybe we can shine a new light on the social, cultural, political, and organisational forces that shape our understanding of ourselves and the

world we inhabit. Critical reflexivity is less about the bookends and more in the real wisdom that lies within the voluminous life texts that reside between them.

At this time of 6.30am, I thank you, the reader, for journeying with me through this day of reflection which has traversed multiple personal and professional domains, raising as many questions as answers given. I trust that our passage has been insightful, sometimes discombobulating, and at the very least, potentially transformative. It is now time, to take these multiple questions and emerging insights back the theatre of practice where they can be thrashed out systematically, implemented, and crash tested in the rough and tumble of the Irish mental health world. It is now time to return to base and *dance* rather than *wrestle* with my transformative ideals; to engage critically with the personal, professional, organisational, socio-cultural, and political; to throw a critical yet gentle eye upon the systems within which we work, learn, and live our lives. If the works I proffer are to have truly transformative potential, it will necessitate residing within the professional world and concurrently standing outside of everyday practice. As this part of the journey draws to a close and another day of learning dawns, it is worth remembering that:

> No problem can be solved from the same level of consciousness that created it.
>
> (Einstein, cited in Weld, 2012, p.28)

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Appendices

Appendix I: Summary of Artefacts for Consideration

SAOR Model	
Artefact 1:	O'Shea, J., Goff, P. and Armstrong, R. (2017) *SAOR Model: Screening and Brief Intervention for Problem Alcohol and Substance Use in Acute, Primary Care and Community Settings*. (2nd Edition), Dublin: Health Service Executive.
Artefact 2:	GAA (2014) *GAA ASAP Programme Coaching for Confidence SAOR Booklet*, Dublin: Gaelic Athletic Association.
Artefact 2a:	GAA ASAP Programme – Booklet and GAA ASAP Programme – Link to web page (http://www.gaa.ie/news/the-gaa-asap-programme/)
Artefact 3:	HSE (2012a) *A Guiding Framework for Education and Training in Screening and Brief Intervention for Problem Alcohol Use For Nurses and Midwives in Acute, Primary and Community Care Settings*, Dublin: Office of Nursing and Midwifery Services Director, Health Service Executive
Artefact 4:	O'Shea, J. and Goff, P. (2009) *SAOR Model: Screening and Brief Intervention (SBI) for Problem Alcohol Use in the Emergency Department & Acute Care Settings,* Dublin: Health Service Executive.
Mental Health Initiatives	
Cognitive Behavioural Therapy (CBT) Training	
Artefact 5:	HSE (2013) *Guiding Framework Certificate in Basic Cognitive Behavioural Skills for Practice*, Dublin: Office of Nursing and Midwifery Services Director, Health Service Executive.
Artefact 6:	Duffy, M., Gillespie, K. and O'Shea, J. (2013) 'How Effective is a Short Cognitive Behavioural Skills Training Programme for Mental Health Staff: An Evaluation Based on Trainee Responses', *Behaviour and Cognitive Psychotherapy*, 42(06), pp. 653-667.
Artefact 7:	O'Shea, J., Goff, P. and Gillespie, K. (2010) *Cognitive Behavioural Skills for Practice: A Stepwise Approach to Enhancing Clinical Practice Based Upon Cognitive Behavioural Therapy Methods – A Model for Delivery in the Irish*

	Health Service, Dublin: Health Service Executive.
Artefact 8:	*Introduction to Cognitive Behavioural Interventions* (CBT) – Course descriptor.
Clinical Supervision Framework	
Artefact 9:	HSE (in progress) *Clinical supervision for nurses working in mental health Services: A guide for nurse managers, supervisors and supervisees,* Dublin: Office of Nursing and Midwifery Services Director, Health Service Executive.
Artefact 10:	HSE (2015) *Clinical Supervision Framework for Nurses Working in Mental Health Services*, Dublin: Office of Nursing and Midwifery Services Director, Health Service Executive.
Artefact 11:	*Introduction to Theory and Practice of Clinical Supervision In Psychiatric and Mental Health Nursing*– Course Descriptor
Recovery College South East	
Artefact 12:	HSE (2018) *Recovery Education Guidance Document 2018-2020: Supporting the Implementation of 'A National Recovery Framework for Mental Health 2018-2020'*, Dublin: Health Service Executive.
Artefact 13:	Recovery College South East – Link to college web page:https://www.recoverycollegesoutheast.com/ Recovery College South East – Link to graduation/James O'Shea as chair of college committee presenting awards. www.recoverycollegesoutheast.com/graduation.html

Other Works

The artefacts presented above for consideration form part of a larger body of public works which are listed below:

HSE (2017) *Best Practice Guidance for Mental Health Services*, Dublin: Health Service Executive. Link to website: https://www.hse.ie/eng/services/list/4/mental-health-services/mental-health-guidance/training/
HSE (2017) *Guiding Framework for the Education, Training and Competence Validation in Venepuncture and Peripheral Intravenous Cannulation,* Dublin: Office of Nursing and Midwifery Services Director, Health Service Executive. Link to website: https://www.lenus.ie/handle/10147/622531
O'Shea, J. (2017) *Mindfulness in Professional Practice: Course Workbook*, Unpublished Course Materials (available upon request).
O'Shea, J. (2017) *Mindfulness: Pre-Course Reading*, Unpublished Course Materials (available upon request).
O'Shea, J. (2016) *Mindful Recovery from Addiction: A 12 Week Recovery Programme* (sample materials available upon request).
O'Shea, J. (2016) *Mindful Recovery from Addiction: Peer Led Monthly Mindful Recovery Meetings* (meeting guide available upon request).
O'Shea, J. (2016) Mindfulness Audio Meditations (short and long audios available upon request).
HSE (2016) *Facilitating Learning in Groups: A Resource Manual for Facilitators Working in Health and Social Care,* Dublin: Office of Nursing and Midwifery Services Director, Health Service Executive.
O'Shea, J. and Murphy, B. (2015) *Report of the Aiséirí Underpinning Process*, Cahir: Aiseiri Unpublished Organisational Report (available upon request).
O'Shea, J. (2011) *Addiction Treatment Outcome Studies and their Implications for Practice,* Waterford: Health Service Executive (available upon request).

Appendix II: Five Strands for Judging the Quality of Autoethnographic Research (Chang, 2016)

Authentic and Trustworthy Data	Does the autoethnography use authentic and trustworthy data? – This generally requires multiple sources of data, as memory alone can fade and become distorted over time. A clear outline of the data collection process is also required.
Accountable Research Process	Does the autoethnography follow a reliable research process and show the process clearly? – This requires a clear explanation and critique of the research process along with inherent strengths and weaknesses.
Ethics Toward Others and Self	Does the autoethnography follow ethical steps to protect the rights of self and others presented and implicated in the autoethnography? – This requires consent from all participants involved in the research prior to data collection. Autoethnographers must also ensure their own welfare and consider matters like personal over exposure.
Socio-cultural Analysis and Interpretation	Does the autoethnography analyse and interpret the socio-cultural meaning of the author's personal experiences? – This requires the autoethnographer to engage in analysis of their own experiences in the context of others and the socio-cultural environment within which they were created. This necessitates critical reflexivity and cultural analysis.
Scholarly Contribution	Does the autoethnography attempt to make a scholarly contribution with its conclusion and engagement of the existing literature? – This

	requires the research to be both relevant and transferrable to the broader community of practice. This includes connecting to other scholarly works within the field of study (Chang, 2016, p. 448).

(See Chang, 2016, p. 448).

Appendix III: Ten Foundational Ethical Guidelines

Consent	
1.	*Respect Autonomy:* Voluntary participation, ensure documented and informed consent.
2.	*Process Consent:* Reaffirm consent at each stage of the research.
3.	*Recognise Conflict of Interest:* When gaining consent after manuscript is written – avoid coercive influence.
Consultation	
4.	*Consult with Others*: Consult with research boards etc.
5.	*Do not Publish:* Do not publish anything that we would not show to the persons mentioned in the text
Vulnerability	
6.	*Beware of Internal Confidentiality*: Be sensitive to the risk of exposing confidence between participants.
7.	*Treat Autoethnography as Inked Tattoo:* Anticipate author's future vulnerability.
8.	*Photovoice Anticipatory Ethics Claims:* Just as no photo is worth harming others for, no story is worth harming others for, therefore minimise the risk of harm.
9.	*Nom de Plume:* Use *nom de plume* if unable to minimise risk to others.
10.	Assume all will Read: Assume that all people in the text will read it one day.

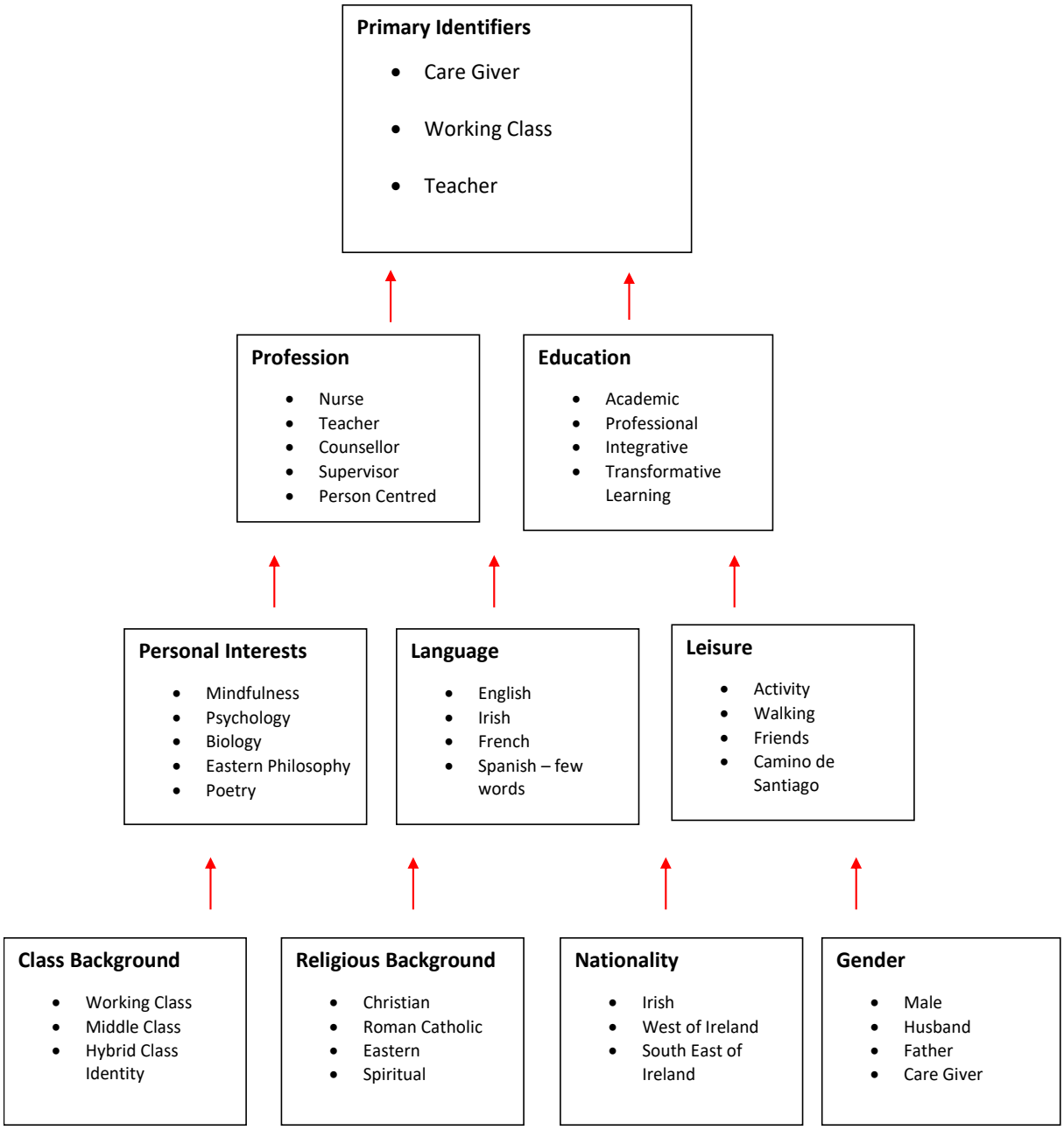
(Tolich, 2010, pp. 1607–1608)

Appendix IV: Protection of Self and Others

Informed Consent	I met with and appraised my colleagues/collaborators of this doctorate and context statement. All agreed to the process. I undertook to update them of developments or any changes in direction to facilitate reaffirmation of consent at each stage.
Confidentiality	I have discussed confidentiality in detail with all colleagues/ collaborators. Some have indicated that they are happy to have their first names used, and for others I have used pseudonyms. Recognising the importance of their contribution to the story, I have sought and received permission from Paul and Ruth (co-authors of SAOR), my colleagues Brendan and Clare, my sons Adam and Dylan, and my wife Anne Marie to use their first names. In all other cases I have used pseudonyms. I have amended or omitted some details within my reflections and within my personal autoethnography to protect the identities of others.
Ethical Consultation	I have sought ongoing advice and engaged in ethical conversations with my academic supervisors, clinical supervisors, and experienced colleagues at each stage of the process.
Preventing Harm	I continue to reflect upon and engage with my academic supervisors, clinical supervisors, and experienced colleagues for the purpose of teasing out issues of preventing harm to myself and others who are/may be identifiable in this context statement.
Assuming Exposure	In all deliberations on content and reflections, I am presuming that this context statement may enter the public domain. I have offered colleagues/collaborators an opportunity to read excerpts that pertain to them. I have discussed references to my deceased mother with my sister who has reviewed and approved relevant parts of the text.
Standing Over It	I plan to complete a piece of work that has integrity and substance. I will need to be satisfied that, when invited to do so, I can stand over the integrity of the work and the ethical standards therein.

Appendix V: Culture Gram

The culture gram below (adapted from Chang, 2008) outlines three primary identifiers, the foundations upon which the works are built.



Appendix VI: Stories from the Western Front

A number of vignettes are utilised here to capture the real time experiences and events which are influential in the personal autoethnography presented in Chapter 3. The vignettes below are representative of lived experiences. They were written from recall between January and June 2018. Names have been changes/omitted to protect confidentiality of those emerging in the stories:

Marty

Marty just dropped in; there he was standing in the kitchen when I returned from school. Marty was a homeless man who travelled the roads of County Clare in the west of Ireland during the 1970's. He generally returned to Leabashioda, my home village, two to three times a year. He sat down without too much ceremony: "God bless you Susie, that's a grand bit of bread". Two mugs of tea and eight slices of homemade brown bread later: "Is there any chance you would put a bandage on that big toe of mine, that auld abscess is howling at me again". I sat silently and watched. "Marty you will have to watch that toe or you will lose the leg", my mother scolded as she cleaned and dressed his foot. "I am a nuisance to you Susie, Marty uttered". "You are no trouble Marty, you are always welcome here. I am delighted to see you". How are they all in Kilkee?". "Ah the Murphy's are getting old Susie. I don't know how long they will be there". "Well tell them I said hello" was my mother's reply. A half-hour later he was gone: off to do what he loved most, travel the roads of rural Ireland and embrace the hospitality of those who welcomed him along the way. "God speed you Marty, don't forget the bit of brown bread and ask Mary Cashin in Kilrush to have a look at that toe for you" was my mother's farewell.

No Meat

I am sitting at our small kitchen table. It is dinner time, usually about 6.30pm when my father arrives home from work. I watch the dance. Mam has no meat on her plate. She says she doesn't really like it. I have a small portion with my father's being a little larger. "Mansie (his pet name for me) I have enough of that meat, I'm full. Will you ate a small bit of this?". "No Daddy, I have enough".

Dark Days

My mother sat at the kitchen table with a cup of tea and a cigarette. She looked sad, longing and forlorn; she gazed into an abyss. Within that void I glimpsed loss, hopelessness and darkness. “Mammy are you all right?”, “Yes James I am grand” was her response through a tearful smile. These dark times passed for Mam and were replaced by periods of happiness, muted joy and laughter. But the darkness always loomed, it always returned. I had never heard of the word ‘depression’, but I knew something was wrong. One Tuesday we went to a big house. We saw a lady in a white coat. She gave Mam some tablets and we went home. I now recognise that place as Our Lady’s Hospital in Ennis. In the 1970’s it was our local mental hospital. Mam was an outpatient at the time.

New Class

I arrived in class full of gusto, childish fantasy and optimism, having been the brightest boy in my class during all of my previous education. My new teacher [name omitted] was related to a local person who my father worked for. S/he knew our stock: poor working class and disadvantaged. His/her disinterest was clear. I was to be kept in my place. I got four slaps of his/her cane on one occasion as anger was displaced from a middle-class student who could not be punished for fear of consequences. My father as an ordinary worker had no voice, so I was fair game. My grades slipped, I felt increasingly isolated and angry. That year marked the beginning of a downward spiral where I slipped from top of the class to somewhere well down the line. I lost interest in learning, homework and school activities. I was lost: I was what I now recognise as disenfranchised.

(* details changed or omitted to protect identity of the teacher and his/her family)

Drugs Education

Session 1: Drugs Education in Clondalkin

February 1997 - There I stood, sweating and trembling, my knees about to buckle. “What do you see as the main factors leading to drug use in the community?” I whimpered nervously. “There is no government investment here”, “our children have no jobs”, “the government and you lot in the Health Board have abandoned us”. God that wasn’t what I wanted to hear. I was hoping for some nice sanitised answer that would get me out alive. I stumbled, fumbled and shook my way to the end of the drug education session in the west Dublin suburb of Clondalkin. Despite nearly having multiple heart attacks at the tender age of twenty-five, I knew that I was in the right place: teaching, learning, and struggling with ordinary people. That was where I belonged.

Session 2: Drugs Education in Clondalkin

I braved it and returned to deliver the second session of the Health Board drugs education programme. The implicit message from my employers was to pacify the community and reduce the emerging social unrest which had arisen in protest against our medicalised solutions to problem drug use: methadone treatment, needle exchange, and health education were the order of the day. As I stumbled along it became abundantly clear that there was no appetite for my conservative quasi middle-class presentation. I took a risk, asking: “What would it be like if you, the local community, came up with the solutions?”. Everything changed. “We could look at all the causes here on our road”, “we could look at some of the causes of unemployment”, “we could look at our part in it”, “we could look at what we really need from you lot in the Health Board”, “we could see why our children leave school so early”, “we could ask drug users what they really need”, “we could look at parenting classes”, “we could set up our own programmes in the community, for the community, and run by us in the community”.

Appendix VII: Personal, Professional, Learning & Development Timelines

Learning & Development Timelines*					
1990 - 1995	**1995 - 2000**	**2000- 2005**	**2005 - 2010**	**2010 - 2015**	**2015 - 2020**
• Registration Psychiatric Nursing • Registration General Nursing • Qualification in addiction counselling	• Higher Diploma Adult & Community Education – encountered person-centred ideologies • Master's Adult & Community Education – encountered transformative learning ideologies	• BSc Counselling & Psychotherapy • Motivational Interviewing TTT – deepened appreciation of person-centred ideologies	• BSc Counselling & Psychotherapy (completed 2007)immersed in person-centred ideology • Cert CBT – immersed in structured therapeutic approach	• Master's in Supervisory Practice – re-engaged with both transformative & person-centred ideologies • HDip Counselling	• Mindfulness Teacher Training
Career Development Timelines*					
1990 - 1995	**1995 - 2000**	**2000- 2005**	**2005 - 2010**	**2010 - 2015**	**2015 - 2020**
• Initial Nursing & Counselling Training • Nursing/Counselling clinical practice	• Community Education • Staff Learning & Development	• Mam died • Moved to different Health Board • Returned to clinical role • Management of Staff Learning &Development	• Management of Staff Learning & Development • National leadership position (Substance Misuse Services)	• Management of Staff Learning& Development • National Leadership Position (Mental Health Services)	• Management of Staff Learning & Development • National Leadership Position (Mental Health Services) • Return to Regional Role - Management of Staff Learning& Development
Personal Development Timelines					
• Entered world of healthcare as qualified professional • Married Anne Marie • Bought first home	• First son Dylan born • Moved house • Went to university as an adult	• Re-located from Dublin to South East of country • Moved house twice • Attended intensive therapy and supervision as part of psychotherapy training	• Second son Adam born • Achieved black belt in Karate at age 42 (bucket list achievement)	• Moved house • Developed close friendships with colleagues of similar personal and professional interests	• First son Dylan left home for college • Walked part of Camino de Santiago pilgrimage with second son Adam • Commenced doctorate in professional studies (public works programme – Middlesex University)

* See Curriculum Vitae

Personal & Professional Learning & Development – Commentary

As I reflect upon my adult learning and professional development, three broad timeframes emerge: (i) 1990–2000: Setting the Foundation, (ii) 2000–2010: Making My Move, and (iii) 2010–2020: The National Stage.

1990 – 2000: Setting the Foundation

During the 1990s, I committed to Anne Marie, got married, established a home, and started a family with the birth of our eldest son Dylan. I began to establish a career and gained basic professional and academic qualifications. In going to university as an adult, I had the opportunity to be immersed in transformative learning ideologies. This created a significant disorientating dilemma (see Mezirow, 2009) where I began to reflect upon, critique, connect with, and articulate underlying personal philosophies of person-centeredness, change, transformation, and the value of learning. This occurred within a tangle of social, political, professional, and academic contexts, including the drugs education of the 1990s post the *Rabbite Report* (Government of Ireland, 1997), community education, reform of health boards, universities embracing social justice issues, unrest in working class communities, and significant changes in the post *commission* world of nursing (Government of Ireland, 1998). This socio-cultural alchemy facilitated a transmutation in both my personal and professional worlds. It would be fair to say that consequent disorientating dilemmas created a leap forward in the evolution of my personal, professional, and career development, where I transitioned from a role of basic grade nurse to believing that I could facilitate real change in myself and others. In many ways, it seemed as if engagement with this new environment surfaced an internal knowing which I could not suppress and could not yet fully articulate. My Identity as teacher and facilitator of learning was fashioned, honed, and fine-tuned. I began to embrace an identity as agent of change.

2000 – 2010: Making My Move

My mam died in the early 2000s, leaving me with monstrous grief combined with a major identity crisis. We subsequently made a decision as a family to move from Dublin which was the centre of everything at the time, to the rural South East of Ireland along with our now two children, as Adam was born in 2001. These two significant transitions undoubtedly led to another key learning point, another significant dilemma. Having

achieved status, comfort, and safety in my previous roles, I was now forced to re-establish myself in a rural South East lifestyle, within a health board area that held the *Dublin experience* in a combined clutch of awe and distrust. I had to rebuild if I was to survive. I quickly achieved a number of personal and learning goals and began to believe that I could facilitate significant change in terms of early intervention for people presenting with alcohol and substance related problems. This, I thought, could be part of my morphing into a new professional identity. I re-established contact with a former colleague and friend (Paul) and engaged in professional conversations that led to an early prototype of what later became the SAOR model of SBI for problem alcohol and substance use (O'Shea et. al., 2017; Armstrong et. al., 2011; O'Shea and Goff 2009,). Paul and I became the go-to people for Brief Interventions in what was the South Eastern Health Board at the time. This phase marked a major transition, a movement towards developing models and frameworks that would inform practice, facilitate learning, and create a context for transformation.

2010 - 2020: The National Stage

During these years I returned to university for a second time to complete another master's programme which reignited my somewhat dwindling flame of person-centred and transformative ideologies. I realised that if the projects I was developing were to reach their full potential and make a significant contribution, I would have to make strategic links with key stakeholders and projects nationally. In response to this realisation, I extended and deepened professional relationships locally, regionally, and nationally. It also became clear that I would have to take on national leadership roles if I was to have the influence, authority, and credibility to progress significant projects. During this time, my eldest son's leaving home to go to college sparked a realisation that I was middle-aged and in the final segment of my career. If I were to make a significant contribution to my professional world, now was the time.

As I reflect upon this journey of personal and professional development, I wonder about the drivers of my passion for change, transformation, learning, and development in myself and others. Why was I not satisfied, like many of my colleagues, with a safe secure relatively stress-free community mental health nursing post? My formative years offer some significant insights (see Chapter 3).

Appendix VIII: Curriculum Vitae

JAMES O'SHEA

Curriculum Vitae

Career History

November 2004–to date *(Health Service Executive, South).*	**Director – Regional Centre of Nursing and Midwifery Education** *(substantive post with two periods of secondment to national leadership roles – see below)* • Overall responsibility for strategic, operational, human resource, and financial management of Regional Centre of Nursing & Midwifery Education across five counties. • Managing and maintaining key stakeholder relationships for continuing education across HSE, voluntary, and community sectors. • Managing and supporting the implementation of national initiatives.
December 2016–April 2018 *Health Service Executive, Office of Nursing and Midwifery Services Director.*	**Director - Nurse Education (Mental Health Nursing) – National Post** (seconded) • National Lead for Mental Health Nurse Education. • Responsibility for development and liaising with key stakeholders and partners on education, workforce, and quality initiatives. • Responsibility for development of national guidance frameworks (e.g. Clinical Supervision).
April 2007–April 2009 *Health Service Executive, Dublin.*	**Project Manager – HSE National Addiction Training Programme – National Post** (seconded) • Managing the strategic development and operational roll-out of a national addiction training programme across the Republic of Ireland. • Overall responsibility for strategic, operational, human resource, and financial management of national education programme. • Developing and managing strategic local, regional, national, and international educational partnerships.

August 2004–November 2004 *South Eastern Health Board, Waterford.*	**Specialist Co-ordinator - Centre of Nurse Education** • Co-ordination of broad range of continuing professional education and clinical skills programmes for nursing services.
August 2003–August 2004 *South Eastern Health Board, Waterford.*	**Liaison Psychiatric Nurse/Addiction Counsellor** • Establishing liaison counselling service within large regional acute hospital. • Providing consultancy and advice to senior hospital and community care clinicians. • Implementing and streamlining information management systems for local and national data management. • Establishing a comprehensive brief intervention training programme regionally with national application.
February 2000–August 2003 *South Western Area Health Board, Dublin.*	**Training and Development Officer** • Establishing and managing multi-disciplinary staff training and development department. • Overall responsibility for strategic, operational, human resource, and financial management of staff training and development. • Managing major inter-disciplinary clinical training programmes. • Managing and maintaining key stakeholder relationships during a time of major change (i.e. dissolution of Eastern Health Board).
February 1997–February 2000 *Eastern Health Board.*	**Education Officer** • Establishment and coordination of community-based health promotion and substance misuse prevention service. • Development of strategic partnerships to support implementation of programmes. • Development of capacity within community organizations and voluntary sector networks.
September 1993–February 1997 *Eastern Health Board.*	**Psychiatric Nurse/Addiction Counsellor** • Provision of community-based addiction counselling service (assessment, key working, brief intervention, therapeutic counselling, and multi-disciplinary case management).

March 1992–September 1993 *St. Michael's Hospital, Dublin.*	**Post Graduate Student General Nurse** • General Nurse training.
January 1990–March 1992 *St. John of God Hospital, Dublin.*	**Staff Nurse (Psychiatry)** • Clinical practice in acute mental health, ward management, and mentoring of student nurses.
September 1986–December 1989 *Regional Psychiatric Nursing School, Waterford.*	**Student Psychiatric Nurse** • Psychiatric Nurse training.
Part Time and Voluntary Roles	
2007 – to date *HSE National Addiction Training programme.*	**Member of National Executive.**
1995–2015 *Maynooth University.*	**Lecturer and Academic Advisor.**
2005–2007 *Waterford Institute of Technology.*	**Member Postgraduate Curriculum Development Group.**
2000–2003 *Irish Association of Alcohol & Addiction Counsellors (IAAAC).*	**Chairperson of Training and Professional Development Committee.**
2003–2004 *Irish Association of Alcohol & Addiction Counsellors (IAAAC).*	**Member of Fitness to Practice Committee.**
2000–2005 *Dublin City University.*	**Lecturer and Clinical Supervisor.**
1998–2000 *University of Dublin, Trinity College.*	**Tutor and Clinical Supervisor.**

Major Academic Awards	
2014 *Dublin City University.*	**Master's Degree in Supervisory Practice** *(first class honours).*
2007 *Middlesex University.*	**BSc (Hons) Degree in Counselling and Psychotherapy** *(first class honours).*
1998 *Maynooth University.*	**Master's Degree in Adult Education** *(second class honours).*
1997 *St. Patrick's College, Maynooth.*	**Higher Diploma in Adult Education** *(first class honours).*
Nursing Qualifications	
1993 *St. Michael's Hospital, Dublin.*	**Registration Certificate in General Nursing** *(honours).*
1989 *Regional Psychiatric Nursing School, Waterford.*	**Registration Certificate in Psychiatric Nursing** *(honours and best academic nurse in psychiatry**).***
Other Professional Qualifications & Minor Academic Awards	
2016 *Institute of Mindfulness Based Approaches Germany.*	**Professional Certificate in Mindfulness Teaching** (MBSR, MBCT)**.**
2014 *Human Givens College, London.*	**Practitioner Higher Diploma in Counselling and Psychotherapy** *(first class honours).*
2010 *Leeds University.*	**Certificate in Cognitive Behavioural Coping Skills.**
2003 *International*	**Motivational Interviewing Trainer Certification.**

Motivational Interviewing Trainers Network.	
1993 *Royal College of Surgeons, Dublin.*	**Diploma in Legal and Ethical Aspects of Nursing.**
1992 *Royal College of Surgeons, Dublin.*	**Diploma in Counselling.**
1991 *St. John of God Hospital, Dublin.*	**Professional Certificate in Alcohol Counselling** *(first class honours).*

Publications

Peer Reviewed Publications

- Duffy, M., Gillespie, K. and O'Shea. J. (2014) 'How do trainees rate the impact of a short cognitive behavioural training programme on their knowledge and skills?' *Behavioural and Cognitive Psychotherapy*, 42(6), pp. 653–667.
  (Co-author and co-developer of CBT education programme)

National Guiding Frameworks

- HSE (in progress) *Clinical supervision for nurses working in mental health Services: A guide for nurse managers, supervisors and supervisees,* Dublin: Office of Nursing and Midwifery Services Director, Health Service Executive.
  (Lead author and co-chair of national working group)

- HSE (2018) *Recovery education guidance document 2018-2020: Supporting the implementation of 'A national recovery framework for mental health 2018-2020'*, Dublin: Health Service Executive.
  (Contributing author and member of national working group)

- O'Shea, J. Goff, P. and Armstrong, R. (2017) *SAOR model: Screening and brief intervention for problem alcohol and substance use in acute, primary and community care settings* (2nd ed), Dublin: Office of Nursing and Midwifery Services Director, Health Service Executive.
  (Lead author and co-developer of SAOR model)

- HSE (2017) *Best practice guidance for mental health services*, Dublin: Health Service Executive.
  (Contributing author and member of national working group)

- HSE (2017) *Guiding framework for education, training and competence validation in venepuncture &peripheral intravenous cannulation for nurses &midwives*, Dublin: Office of Nursing and Midwifery Services Director, Health Service Executive.

  (Co-lead author and co-chair of national working group)

- HSE (2016) *Facilitating learning in groups: A resource manual for facilitators working in health and social care,* Dublin: Office of Nursing and Midwifery Services Director, Health Service Executive.

  (Contributing author co-chairperson national working group)

- HSE (2015) *Clinical supervision framework for nurses working in mental health services,* Dublin: Office of Nursing and Midwifery Services Director, Health Service Executive.

  (Contributing author and co-chair of national working group)

- HSE (2013) *Guiding framework certificate in basic cognitive behavioural skills for practice,* Dublin: Office of Nursing and Midwifery Services Director, Health Service Executive.

  (Co-lead author and co-chair of working national group)

- HSE (2012a) *A guiding framework for education and training in screening and brief intervention for problem alcohol use for nurses and midwives in acute, primary and community care settings*, Dublin: Office of Nursing and Midwifery Services Director, Health Service Executive.

  (Contributing author, member of national working group and co-developer of model)

- O'Shea, J. and Goff, P. (2009) *SAOR model: Screening and brief intervention (SBI) for problem alcohol use in the emergency department and acute care settings,* Dublin: Health Service Executive.

  (Lead author and co-developer of model)

Other Publications/Reports

- O'Shea, J. and Murphy, B. (2015) *Report of the Aiséirí underpinning process*, Cahir: Aiseiri Treatment Centres.

  (Lead author)

- O'Shea, J. (2011) *Addiction treatment outcome studies and their implications for clinical practice*, Dublin: Health Service Executive.

  (Author)

- O'Shea, J., Goff, P. and Gillespie, K. (2010) *Cognitive behavioural skills for practice: A stepwise approach to enhancing clinical practice based upon cognitive behavioural therapy methods – A model for delivery in the Irish Health Service,* Dublin: Health Service Executive.

(Lead author and co- developer of CBT education programme)
Professional Registrations
Nursing and Midwifery Board of Ireland – Registered Psychiatric Nurse and Registered General Nurse
British Association of Counselling and Psychotherapy- Registered Member
Addiction Counsellors of Ireland – Accredited Member and Supervisor
Motivational Interviewing Trainers Network – Member/Trainer

Appendix IX: SAOR Model of SBI (Screening & Brief Intervention): Irish Policies, Activities, Influences & Outcomes

Timeframes	Policies & Developments	Influences & Outcomes
2000 - 2005	• No reference to Screening & Brief Intervention (SBI) in national policy documents during these years.	• No specific policy context for developments - work commenced and progressed within a policy vacuum.
	• Miller and Rollnick (2002) Motivational Interviewing publication.	• Motivational Interviewing becoming accepted in Ireland – set context for developing briefer interventions for problem alcohol use.
	• Commencement of Alcohol Liaison Service in Major Regional Hospital (2003).	• I began training and lobbying in order to to create awareness of importance of effective SBI for problem alcohol use in acute care across former South Eastern Health Board.
	• SBI training for alcohol in Major Regional Hospital utilising traditional Models (2003–2004).	• Limitations of contemporary models of SBI for problem alcohol use emerged and I articulated them to local/regional policy makers and managers.
	• Expansion of SBI training for alcohol across South Eastern Health Board (2004–2006).	• Initiative remained confined to one health board (former South Eastern Health Board) area with low to moderate levels of support from policy makers and managers.
2005 - 2010	• Irish College of General Practitioners (2006) *Helping Patients with Alcohol Problems: A Guide for Primary Care Staff.*	• Guidance for primary care staff available – no guidelines for acute hospital sector – it became clear that an initiative was required to progress the use of evidence based SBI's beyond primary care.
	• Development and Publication of Course curriculum for *Dealing with Alcohol Misuse in Acute Care Settings* (2006) - precursor to SAOR.	• I developed a new course publication *Dealing with Alcohol Misuse in Acute Care Settings* (This offered first curriculum for SBI training

		within acute care settings in Ireland).
	• Report of the Implementation Group on Alcohol Misuse (2008).	• The impetus to develop alcohol based SBI's began to grow.
	• HSE Transformation Programme (2007–2010). • National Substance Misuse Strategy (2009–2016).	• HSE Transformation programmes offered policy context for change, innovation and the transfer of learning from local to national initiatives. • National Substance Misuse Strategy (2009–2016) provided policy context for developing early intervention programmes for substance misuse.
	• Publication of SAOR 1st ed for Dealing with Alcohol in Acute Care Settings (2009)	• SAOR 1st edition provided first uniquely Irish model for SBI within acute care settings – emerged from recognition of limitations of existing models for both intervention and training in SBI.
	• SAOR project linked to National HSE Transformation Project on Alcohol – *Towards a framework for Evidence Implementing Evidence Based Alcohol Interventions* (2009).	• Links were fostered with the HSE transformation initiative - *Towards a framework for evidence implementing evidence based alcohol interventions*. This was SAOR's first introduction to the national stage. The project continued for 9 years. SAOR began to become established as the model of choice for SBI in acute care settings nationally.
	• Inclusion of SAOR in *National Pilot Project for Screening and Brief Intervention (SBI) in Emergency Departments* (2010).	• SAOR began to significantly shape the HSE transformation initiative - *Towards a framework for evidence implementing evidence based alcohol interventions* in terms of intervention strategies with its increasing

		person-centred emphasis and user-friendly intervention framework.
2010 - 2015	• Publication of National Framework by ONMSD for SBI for Nurses and Midwives based upon SAOR I – *A Guiding Framework for the Education and Training in Screening and Brief Intervention for Problem Alcohol Use* (2011).	• SAOR offered a framework and became the national model for provision of SBI for problem alcohol use by nurses and midwives across the HSE.
	• HSE National Addiction Training Programme (NATP) – SAOR training – 2011 onwards.	• HSE National Addiction Training Programme (NATP) took SAOR on board as the basis for its national training schedule on SBI.
	• National Drug Rehabilitation Framework (2011).	• National Drug Rehabilitation Framework (NDRF) provided policy context for SBI across substance misuse services and we began to promote SAOR as an evidence-based intervention model.
	• National Drugs Rehabilitation Framework Protocols and Common Assessment Guidelines (2011).	• NDRF Protocols and Common Assessment Guidelines provided specific outcome measures for early and brief Interventions and SAOR was increasingly considered the model of choice for intervention. In line with NDRF National Protocols and Common Assessment Guidelines, SAOR supported workers from their first point of contact with a service user, enabling them to deliver SBI and facilitate those presenting with more complex needs with entry into treatment programmes.
	• Feasibility Study on utility of SBI in ED's (2012 0nwards – findings	• SAOR became the model of choice for the first national pilot project on feasibility of

	published by Armstrong in 2014).	delivering SBI's in emergency departments – findings were submitted to a review/steering group which influenced the upcoming national report.
	• Steering Group Report on a National Substance Misuse Strategy (2012).	• The emerging national steering group report firmly located SBI within a menu of intervention strategies. It Included recommendations for(i) alcohol liaison nurses to be employed to coordinate SBI's, (ii) the development of a national screening and brief intervention (SBI) protocol for early identification of problem alcohol use, and (iii) the development of a specific national tailored module on SBI's for problem alcohol use to be included in undergraduate health care professional trainings. • Steering group report enabled the expansion of SAOR training nationally with a specific emphasis on supporting clients with more complex needs who required extended SBI's and facilitated entry to treatment within the HSE and its partner agencies (NGO's).
	• Uptake of SAOR and associated training by regional drug taskforces (2012 onwards).	• Following on from developments in the National Drug Rehabilitation Framework (2011) and National Drugs Rehabilitation Framework Protocols and Common Assessment Guidelines (2011), SAOR became the model of choice for training workers across regional drug taskforces.
	• Training by regional drug taskforces began to include alcohol in work plans nationally (2012).	• Inclusion of interventions for alcohol was driven by the steering group report on a National Substance Misuse Strategy (2012).

		This created increased demand for SBI training in general and SAOR training in particular.
	• National Standards for Safer Better Healthcare – HIQA (2012).	• National Standards for Safer Better Healthcare (2012) created a context for more integrated care provision. This approach supported including early interventions/SBI's in health care delivery.
	• HSE Person Centred Care and Support Supporting services to deliver quality healthcare (2013).	• The HSE Person Centred Care report created a firm foundation for a more person-centred approach which was in keeping with the evolving SAOR model at the time.
	• O'Farrell (2010) *Alcohol Use Among Amateur Sportsmen in Ireland.*	• O'Farrell's (2010) *Alcohol Use Among Amateur Sportsman in Ireland* highlighted the issue of alcohol use amongst amateur sports people in Ireland and created an impetus for the GAA to create responses.
	• Uptake of SAOR by the GAA (Gaelic Athletic Association) as the basis for its Alcohol & Substance Awareness programme (ASAP).	• The GAA is the largest national sports andcultural organisation in Ireland. In becoming the GAA's framework for brief intervention with alcohol and substance misuse issues, SAOR became the hub of the GAA's prevention, education and response for alcohol and drug related issues of their players and members across their national network in every county and every parish in Ireland. "SAOR", the Irish word for free, is attractive culturally. 0ver 800 clubs now have an alcohol and substance misuse policy, and over 900 coaches have been trained to use SAOR. It is now a key aspect of the *Coaching with Confidence* programme and the GAA

		Tobacco, Alcohol and Drug Policy and Guidelines.
	• Publication of 'Towards a framework for implementing evidence-based alcohol' in *Irish medical Journal* (Armstrong and Barry 2014).	• As SAOR was the intervention model utilised for the publication of 'Towards a framework for implementing evidence-based alcohol interventions', its reputation as an evidence-based model for SBI in acute care settings was enhanced and reinforced.
	• *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives*, (Nursing & Midwifery Board of Ireland, 2014).	• Updated ethical and professional standards for nurses and midwives and reinforced the need for the maintenance of skills and competence.
	• Irish College of General Practitioners *Helping Patients with Alcohol Problems: A Guide for Primary Care Staff* (ICGP 2014).	• The ICGP updated their primary care SBI framework offering further impetus to SBI, particularly with alcohol.
	• Alcohol Action Ireland and the HSE took strong policy positions on the risks of alcohol during pregnancy which created a context for intervention (2015 onwards).	• Increasing policy emphasis on risks associated with drinking during pregnancy taking strong policy positions.
	• *Prescription for a Healthy Pregnancy Project* (Saolta, 2015).	• In becoming the model of choice for *Prescription for a Healthy Pregnancy,* SAOR created a template for SBI's in Irish maternity settings. This framework has generated interest amongst other maternity services.
	• *National Standards for Safer Better Healthcare* (HIQA, 2012).	• Increased the impetus for developing and delivering evidence-based interventions.
	• World Health Organization (2010)*Global Strategy to Reduce the Harmful Use of Alcohol,* (Geneva: WHO).	• Maintains emphasis on the need for prevention and early intervention

	• World Health Organization (2011)*European Action Plan to Reduce the Harmful Use of alcohol 2012–2020,Copenhagen*: WHO Regional Office for Europe).	• Maintains emphasis on the need for prevention and early intervention.
2015 - 2020	• Establishment of SAOR Train the Trainer programme, led by Social Inclusion HSE, (2015).	• Establishment of the national train-the-trainer programme extended interest in SAOR beyond the Health Service, with training requests emerging from the Gardai (Irish National Police Service), Probation and Welfare Services, TUSLA (National Child and Family Agency), Youth Services, Traveller/Roma Heath Groups, and a plethora of other agencies.
	• Incorporation of SAOR training into curricula at a number of universities and colleges (2015 onwards).	• SAOR became the preferred model for teaching SBI on a number of university courses with the hope of influencing future generations of health and social care professionals.
	• Scope of Nursing and Midwifery Practice Framework (Nursing and Midwifery Board of Ireland, 2015).	• Updated scope of Nursing and Midwifery Practice creating further impetus for nurses and midwives to utilise the full extent of their skills and competence.
	• EMCDDA (2015) *The Role of Psychosocial Interventions in Drug Treatment*, [Online]. Available at:http://www.emcdda.europa.eu/publications/topics/pods/psychosocial-interventions_en.	• Maintains an emphasis on the role of psychosocial interventions on the treatment continuum.
	• Development of the SAOR National E Learning programme – pilot project in one region (2016) - national process in progress.	• The E Learning pilot project, and expected free to use national roll out, will extend the reach of SBI education both nationally and internationally.

	• Incorporation of SAOR raining into National KPI's (Key performance Indicators for all Substance Misuse Services Nationally (2016).	• Incorporation into national KPI's promoted the use of SBI's across all funded agencies in the substance misuse field and made the delivery of SBI's more likely where SAOR was almost exclusively the model of choice.
	• Incorporation of SBI into National Drug/Alcohol Reporting System (Health Research Board) (2016).	• Incorporation of SBI's into National Drug/Alcohol Reporting System made all funded agencies accountable for delivering and recording SBI's (again SAOR was almost exclusively the model of choice).
	• HSE clinical guidelines on opiate substitution (OSD Guidelines) (2016).	• The inclusion of early intervention on opiate substitution (OSD) guidelines emphasises the importance of extended SBI's with clients who have complex needs. SAOR is the model of choice for SBI in supporting the training of staff in relation to these guidelines across the sector.
	• Inclusion of SAOR in the European Union Reducing Alcohol Related Harm (RARHA) Project Good Practice Toolkit (2016) - RARHA specifically mentions SAOR.	• The inclusion of SAOR in the European Union Reducing Alcohol Related Harm (RARHA) extends the influence of SAOR internationally.
	• Health and Wellbeing Directorate REACT Programme (2016).	• SAOR has provided the model of training in SBI for a number of colleges/universities participating in the REACT programme.
	• EMCDDA (2016) *Emergency Department-based Brief Interventions for Individuals with Substance-Related Problems: A Review of Effectiveness* EMCDDA papers, Luxembourg: Publications Office of the European Union.	• Emphasised the ongoing value of SBI in emergency departments.
	• Publication of SAOR II – Brief Intervention for Alcohol Substance Misuse National Framework for HSE Social Inclusion Services (2017)	• SAOR II publication offers an updated, robust, evidence-based framework for SBI with

		alcohol and substance misuse. The second publication, with a strong person-centred emphasis, has become the HSE Social Inclusion's national model for SBI and associated training – the second edition evolved from a recognition that a broader more comprehensive person-centred model was required to support and influence the diverse range of services now utilising SAOR and seeking training programmes in SBI.
	• Inclusion of SBI in the National Substance Misuse Strategy *Reducing Harm, Supporting Recovery. A Health-Led Response to Drug and Alcohol Use in Ireland 2017-2025,*Ref. 2.1.12 (b) (2017).	• The SAOR project and associated lobbying has heightened the profile of SBI nationally and influenced the National Substance Misuse Strategy (2017 – 2025) in terms of an increased early focus and briefer interventions.
	• Extension of SAOR training programme on the key processes of the National Drugs Rehabilitation Framework (2017).	• Extension of SAOR training within the National Drug Rehabilitation Framework increased the delivery of training for statutory and non-statutory services in SBI nationally.
	• *Connecting for Life, Ireland's National Strategy to Reduce Suicide 2015-2020* (action IO3.2 S).	• Inclusion of SBI in *Connecting for Life, Ireland's National Strategy to Reduce Suicide 2015-2020*addressed alcohol and drug misuse Indicators in suicide and self-harm. It is envisaged that all substance misuse services will utilise SAOR as the preferred model of SBI for these interventions.
	• Inclusion of SAOR training in HSE Social Inclusion Operational Plans - 2015, 2016, 2017, 2018.	• This has kept SAOR to the forefront of SBI/early intervention across Social Inclusion nationally.

	• Requirement for SBI activity reporting in all Service Level Agreements (SLA's) for Section 39 Agencies (NGO's funded by the HSE to Provide Substance Misuse services) - 2017.	• The requirement for SBI activity reporting in all service level agreements (SLA's) for government funded substance misuse agencies increased the use of SBI across services. Such agencies almost exclusively utilise SAOR as the preferred model of SBI for these interventions.
	• Establishment of SAOR Steering groups in 9 HSE CHO's (community health care organisations) across the HSE – 2017.	• Establishment of SAOR steering groups in all 9 HSE CHO's (community health care organisations) will support the coordination of SAOR training and train-the-trainers programme. Once training panels are established they will support the implementation of SBI across HSE Addiction Services, Regional Drug and Alcohol Task Forces (RDAFT's), and funded agencies nationally.
	• SAOR Brief Intervention Pilot Training Project with Mental Health Intellectual Disability Services – Dublin North (Pilot 2017 ongoing).	• The SAOR Brief Intervention Pilot Training Project with Mental Health Intellectual Disability Services extends the utility of SBI in promoting healthy attitudes to alcohol and substance use within an emerging sector of community-based services for people with intellectual disability.
	• National Traveller and Roma .Inclusion Strategy (2017 – 2021)	• The National Traveller and Roma Inclusion Strategy (2017 – 2021) has created a policy platform for development of early intervention for alcohol and substance related issues.
	• Incorporation of SAOR into regional alcohol traveller health	• In response to the National Traveller and

	project (HSE South East).	Roma Inclusion Strategy, HSE South East has Incorporated SAOR into a regional alcohol traveller health project. It is envisaged that this will create a framework for the use of SBI within Traveller and Roma communities who experience significant disadvantage. It is anticipated that the strong person-centred emphasis of SAOR will maximise engagement with services at first point of contact.
	• Best Practice Guidance for Mental Health Services (2017).	• Publication of *Best Practice Guidance for Mental Health Services* with an increased emphasis on recovery orientated and person-centred care offers a policy context for potential utilisation of the SAOR model for SBI within the Irish Mental Health Services
	• Presentation of SAOR Model at National Alcohol Conference (2017).	• Presentation of the SAOR model at the National Alcohol Conference generated significant interest in the model and highlighted achievements of all stakeholders involved in national roll out.
	• Presentation of SAOR Model at International Motivational Interviewing Forum (2017).	• Presentation of SAOR at a recent Motivational Interviewing Network of Trainers Forum (MINT), which is the largest gathering of Motivational Interviewing trainers internationally, has generated significant interest and discussion. This has centred on the integration of more structured

		frameworks with contemporary Motivational Interviewing developments and its utility in services internationally. Conversations are ongoing with a number of international colleagues in relation to the adaptation of SAOR for their services. It has generated interest for acute hospital services in New York in particular, with a number of exploratory meetings taking place.
	• National Substance Misuse Strategy (2017).	• The recent publication of the National Substance Misuse Strategy (2017-2025) has kept SBI on the policy agenda as an early intervention.
	• Best Practice Guidance for Mental Health Services (HSE 2017).	• The Best Practice Guidance for Mental Health Services increases the emphasis on the quality assurance and implementation of evidence-based care.
	• EMCDDA (European Monitoring Centre for Drugs and Drug Addiction), Ireland Profile, (2017).	• EMCDDA highlights the current status of drug use in Ireland and helps to garner political support for early intervention.

Appendix X: Declaration of Authorship

SAOR Model

- *Conceptualisation:* The original SAOR concept was mine, in that it arose from a 'light bulb' moment in trying to conceptualise a new way of delivering Screening and Brief Intervention (SBI) for problem alcohol and substance use. These ideas have been subjected to lengthy critical conversations with my co-developer (Paul), my co-author (Ruth), and many trainers, practitioners, and friends over the years.
- *Design:* I designed the model with input from my co-authors and others over the years.
- *Writing, Literature & Frameworks:*
    - Artefacts 1 & 4: I have been lead-author and undertaken most of the writing of SAOR publications over the years, culminating in my writing approximately 75% of both the first and second editions of the SAOR Model (O'Shea et. al., 2017; O'Shea and Goff, 2009).
    - Artefact 2 & 2a: The core SAOR content for the GAA ASAP Programme, Coaching for Confidence /SAOR Booklet (GAA, 2014) was adapted from SAOR 1st edition (O'Shea and Goff, 2009). I advised on application within the GAA and edited the booklet.
    - Artefact 3: *The Guiding Framework for Education and Training in Screening and Brief Intervention for Problem Alcohol Use for Nurses and Midwives* (HSE 2012a) was led by my colleague Ruth Armstrong. I was responsible for writing approximately 60% of the document content which was based upon the SAOR 1st edition (O'Shea and Goff, 2009). I was a member of the national working group that oversaw and edited the work.

Mental Health Initiatives

Cognitive Behavioural Therapy (CBT) Training

- *Conceptualisation:* The original concept for developing the *CBT Skills for Practice* training programme was mine.
- *Design Writing, Literature & Frameworks:*
    - Artefact 5: I was co-chair of the national group that developed the *Guiding Framework Certificate in Basic Cognitive Behavioural Skills for Practice* (HSE 2013). The work was based largely upon my previous work, and I wrote approximately 90% of and edited the document
    - Artefact 6: I was co-author of the 2013 BABC journal publication (Duffy,

Gillespie and O'Shea, 2013) and was responsible for approximately 33%of the work.

- Artefact 7*:* I was lead author and developer for the *Cognitive Behavioural Skills for Practice* programme (O'Shea, Goff and Gillespie, 2010) and wrote approximately 90% of the document.
- Artefact 8: I designed and wrote 100% of the introduction to Cognitive Behavioural Interventions (CBT) – Course descriptor.

Clinical Supervision Framework

- *Conceptualisation:* The original idea of developing and providing large scale training for mental health nurses on clinical supervision was mine. I then lobbied the national nursing and midwifery office (ONMSD) to develop a guiding framework and co-chaired subsequent national committees and working groups.
- *Design Writing, Literature & Frameworks:*
  - Artefact 9: I am lead author and co-chair of the national consultation group for development of the current national document, *Clinical supervision for nurses working in mental health Services: A guide for nurse managers, supervisors and supervisees.* Once this is completed, I will have written in excess of 80% of the work and co-edited the document.
  - Artefact 10: I was co-chair of the national group that developed the ONMSD (2015) *Clinical Supervision Framework for Nurses Working in Mental Health Services.* I wrote approximately 60% of the document.
  - Artefact 11a: I designed, developed and wrote 90% of the *introduction to the Theory and Practice of Clinical Supervision in Psychiatric and Mental Health Nursing* training programme.

Recovery College South East

- *Conceptualisation:* The concept of developing a Recovery College South East emerged from many conversations and the collaborative endeavours of Claire (current college co-ordinator) and myself. The notion of including people experiencing substance misuse challenges was mine.
- *Design Writing, Literature & Frameworks:*
  - Artefact 12: I was a member of the national group which developed the HSE (2018) *Recovery Education Guidance Document.* My primary contribution relates to representing mental health nursing nationally on the group,

reviewing all content, and contributing to the writing and editing of the document.

- Artefact 13:I am co-founder and chairperson of the governing committee for Recovery College South East.

Other Works

HSE (2017) *Best practice guidance for mental health services*, Dublin: Health Service Executive.

Link to website: https://www.hse.ie/eng/services/list/4/mental-health-services/mental-health-guidance/training/

(Contributing author and member of national working group).

HSE (2017) *Guiding framework for the education, training and competence validation in venepuncture and peripheral intravenous cannulation,* Dublin: Office of Nursing and Midwifery Services Director, Health Service Executive.

Link to website: https://www.lenus.ie/handle/10147/622531

(Co-lead author and co-chair of national working group).

O'Shea, J. (2017) *Mindfulness in professional practice: Course workbook*, Unpublished Course Materials (available upon request).

(Author and developer).

O'Shea, J. (2017) *Mindfulness: Pre-course reading*, Unpublished Course Materials (available upon request).

(Author and developer).

O'Shea, J. (2016) *Mindful recovery from addiction: A 12 week recovery programme* (sample materials available upon request).

(Author and developer).

O'Shea, J. (2016) *Mindful recovery from addiction: Peer led monthly mindful recovery meetings* (meeting guide available upon request).

(Author and developer).

O'Shea, J. (2016) Mindfulness audio meditations (short and long audios available upon request). (Author and developer).
HSE (2016) *Facilitating learning in groups: A resource manual for facilitators working in health and social care,* Dublin: Office of Nursing and Midwifery Services Director, Health Service Executive. (Contributing author and co-lead of national working group).
O'Shea, J. and Murphy, B. (2015) *Report of the Aiséirí underpinning process*, Cahir: Aiseiri Unpublished Organisational Report (available upon request). (Lead author).
O'Shea, J. (2011) *Addiction treatment outcome studies and their implications for practice,* Waterford: Health Service Executive (available upon request). (Author).

I confirm that the above declaration accurately reflects my contribution to the public works presented here for consideration and the larger body of work of which they form part.

James O' Shea

Signed 31st October 2018: