Developing a dual diagnosis service in Cork, Ireland by way of participatory action research (PAR)

John Connolly, Liam MacGabhann and Olive McKeown

John Connolly is an Addiction Counsellor and Liam MacGabhann is the Director of Academic Practice, both are based at School of Nursing and Human Sciences, Dublin City University, Dublin, Ireland. Dr Olive McKeown is a Programme Lead (PL), based at School of Nursing and Human Sciences, University of East London, London, UK.

Abstract

Purpose – *Developing a dual diagnosis service in Cork, Ireland by way of participatory action research (PAR) background: internationally there is a growing consensus regarding the ideal of integrated treatment. In Ireland, recommendations identified the need for multi-disciplinary team integration and client participation being central to service development. Such recommendations collectively fit most appropriately with PAR, the methodological and theoretical framework best suited to achieve the objectives of the inquiry. PAR's inclusive philosophy creates processes of negotiation, self-reflexivity and exploration of power issues with the lived experience of communities. Key elements of this approach facilitate the development of emancipatory and participatory democracy whilst highlighting identified social issues through research, learning and action. The paper aims to discuss these issues.*

Design/methodology/approach – *Cyclical processes of planning, action, observation and reflection in cycle one have facilitated the introduction of PAR's methodological framework into the existing public health (Health Service Executive) system of primary care addiction and mental health services. Developing stakeholder relationships in decision making processes has been pivotal in cycle 1 as the process of collective engagement evolves. Stakeholders begin to experience their collective participation in the methods adopted and a collective sense of ownership and commitment to the iterative process begins to take shape. Stakeholders in cycle 1 have participated in multiple data generation methods including: informal interviews, planned discussion and focus groups, multidisciplinary team meetings, testimonials, observations and reflections.*

Findings – *Cycle 1 of this PAR inquiry has engaged stakeholders (service users and their families, practitioners including; academic/practitioners, a consultant psychiatrist, psychologist, mental health nurses, an occupational therapist, psychotherapists, an acupuncturist, an addiction counsellor, an art therapist) in an integrated process of inquiry. PAR methods adopted in this cycle have facilitated particular dual diagnosis service developments and emerging initiatives (previously unidentified). Actions collaboratively planned for and illustrated in this paper include: the implementation of a psychotherapy group and implementing direct access to an acupuncture clinic.*

Originality/value – *Stakeholders collaboratively experience PAR's methodological and theoretical approach which has facilitated service developments in cycle 1 of the inquiry. This sets the stage for the completion of actions already in motion and for further initiatives to continue to evolve as cycle 2 processes emerge.*

Keywords *Dual diagnosis, Mental health, Multi-disciplinary, Integration, Addiction, Participatory action research*

Paper type *Research paper*

Introduction

In Ireland, dual diagnosis is a relatively new phenomenon, both conceptually and as an accepted real social and clinical problem. While policy decisions around any Health Service Executive's (HSE) response appear to be at an impasse; many mental health and addiction

service providers struggle to provide comprehensive health care, in the absence of joined-up thinking at policy level (MacGabhann *et al.*, 2004, 2010a, b; Government of Ireland, 2006, 2009).

Dual Diagnosis as a term describing the co-occurrence of mental ill health and substance misuse, has only relatively recently been recognised in Irish health care policy (Government of Ireland, 2006, 2009). Emerging as a concern for Irish services and national advisory bodies in 2000 the first national study in Ireland on how dual diagnosis was managed within statutory addiction and mental health services identified that there was a fragmented, little formal and generally serial approach to providing care for people who may have a dual diagnosis (MacGabhann *et al.*, 2004). Although policy recommended the development of more effective approaches, there has been no definitive response from statutory services or further investment by responsible government departments (MacGabhann *et al.*, 2010a, b). This is not to say that at local level and on an informal basis services and practitioners are not trying to meet the complex needs of people presenting with dual diagnosis. MacGabhann *et al.* (2004) identified the historical context of practice; highlighting the provision of addiction and mental health services, respectively, functioning in isolation from each other. The report proposed that ideally, dual diagnosis ought to be responded to in an integrated capacity in the community. Furthermore, recommendations from *The National Drugs Strategy* (Government of Ireland, 2009) and mental health policy *A Vision for Change* (Government of Ireland, 2006) identified the need for multi-disciplinary team integration and client participation as central to service development.

Internationally, an integrated treatment model for dual diagnosis (Brunette *et al.*, 2004; Drake *et al.*, 1998) has been recommended at policy level in the UK (Department of Health (UK), 2006), Scotland (Department of Health (DoH England), 2007), Wales (DoH England, 2007), Australia (Australian Government, 2009) and Canada (CAMH, 2006/2007). Although limited, some research outcomes are available regarding benefits of this model to date, available studies suggest implementation over the longer term can facilitate greater engagement than serial or parallel models (Ley *et al.*, 2000; Robinson and Reiter, 2007).

This paper illustrates one local dual diagnosis service in development which has been enabled through the introduction of participatory action research (PAR) methodology. The context for the inquiry follows the co-location of the addiction and mental health services in the environment of primary and community care services in Cork, Ireland (Connolly *et al.*, 2010). Integration of service provision whilst frequently a policy drive and practice aspiration is not always successful as an organisational development (Chandler, 2009) and organisational readiness for this change is a key predictor of success (Drake and Bond, 2010). Where policy directives, legislation and functional reconfiguration of services are concurrently driving integration; for example, in Norway, Finland and Sweden the service developments seem to work well. However, even there with local responsibility for implementation success is often dependent on professional capacity for providing continuity of care (Lindgren *et al.*, 2014). The health system itself needs to support the integration of care (Drake and Bond, 2010; Minkoff, 2001) and without this systemic support integration is considered a challenge (Lindgren *et al.*, 2014). For the present service development, there was a local desire to integrate services and an opportunity because of a restructuring process, though there was not a systemic intention or policy directive to integrate services. Brousselle and Champagne (2011) developed a conceptual model for service integration identifying that there were wider possibilities for successful integration than traditional “merger” or “cooptation” approaches. In particular they identified the relevance of service context and professional/organisational dynamics around a given clientele as informing any approach to integration. PAR (McIntyre, 2008; Rahman, 2008; Swantz, 2008) provided an ideal organisational development methodology that enabled a contextually determined process of integration to evolve.

Aim and objectives of inquiry

The aim of the PAR inquiry is to develop a comprehensive community based service for those who experience and live with dual diagnosis, within the environment of primary and community care services in Cork, Ireland.

This aim endeavours to be met by achieving these objectives:

1. to engage stakeholders in PAR's methodological framework, over current and subsequent cycles, to facilitate a clear pathway to services;
2. to engage stakeholders in a critical reflective process seeking to collectively understand existing and emerging concepts and beliefs relative to dual diagnosis and related service developments; and
3. to enact through PAR, pragmatic developments in service delivery that demonstrate positive outcomes for those experiencing dual diagnosis.

Methodology

Action research (AR) provides a mechanism that generates knowledge about a social system whilst at the same time attempting to change it (Lewin, 1948). Considering, that there were no identified resources or statutory obligation to develop a dual diagnosis service, the methodology would have to enable transformation within existing resources and with the active participation of stakeholders already responsible for delivering mental health and addiction services in the chosen locality for the inquiry and those that use these services. Holter and Schwartz-Barcott (1993) identify four characteristics that underpin AR:

1. collaboration between researchers and practitioners;
2. solution of practical problems;
3. change in practice; and
4. development of theory.

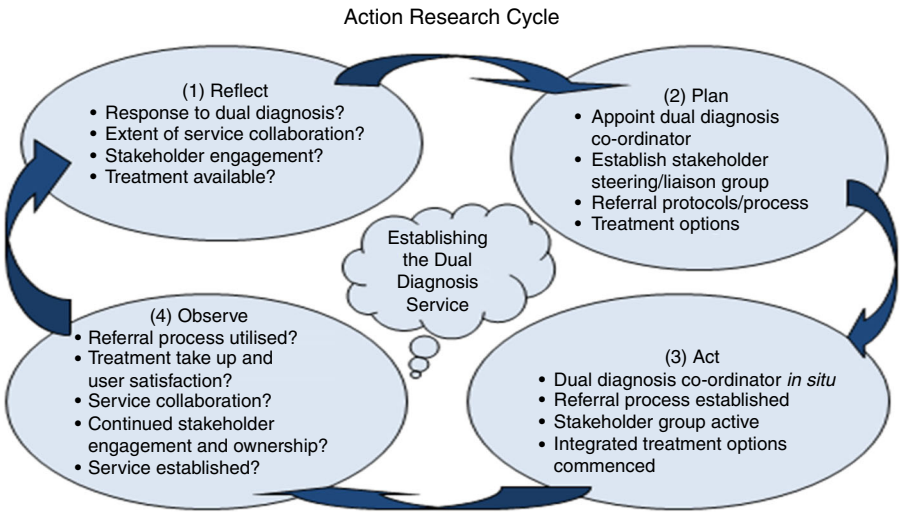
These characteristics enable the integration of the research methodology with the concurrent resources and aspirations of stakeholders seeking to develop the service. On the AR continuum, PAR is participative and emancipatory, whilst enabling researchers themselves to be co-participants in the system transformation (Hart and Bond, 1995). The methodology was drawn from examples identified by Reason and Bradbury (2008) and the appropriateness of this methodology in co-constructing the service with participants. The authors refer to key elements such as goals emancipation, participatory democracy and highlighting social problems through the iterative cyclical process of research, learning and action. Irish government policy direction aspires to a participatory approach with all stakeholders' taking part in service design and development (Government of Ireland, 2006). Reason and Bradbury (2008) contend that "Action research is only possible with, for and by persons and communities, ideally involving all stakeholders both in the questioning and sense-making that informs the research, and in the action which is its focus" (p. 4).

The choice of PAR is not unusual in health care service development and has been on the ascent over the last decade particularly (Burgess, 2006; McDaid, 2006; Lazes, 2007; Watters and Comeau, 2010; Berg-Powers and Allaman, 2012) and it is an appropriate choice to fulfil the policy aspirations of partnership and collaboration in service development.

PAR provides a space for dialogue and critical reflection (McIntyre, 2008). As with Freire's critical concientization (Freire, 1970), it has an emancipatory intent with co-participants being empowered in the process (Koch and Kralik, 2006). With an evolving service new to all, the creation of a reflective dialogue that can accommodate tensions and diverse perceptions amongst participants (Schwartz *et al.*, 2013) was crucial to this development.

Creating an effective transparent process for what is a murky and dynamic service in flux was crucial and maximising participation the key. There are various cyclical frameworks conducive to creating this process and adopted to PAR, generally redefining Lewin (1946/1997) original four step cyclical process (Kemmis and McTaggart, 1988; Stringer and Genat, 2004; McIntyre, 2008) and adapting to the context of inquiry. Likewise for this inquiry an adoption of Lewins process in Figure 1 (Meyer, 1993) was seen as an effective method for enacting the service transformation and one that has maintained robust relevance over time and use.

Figure 1 Cycle 1 – transformation process



Source: Lewin (1946/1997)

One of the authors had established an existing interest amongst stakeholders (Connolly *et al.*, 2010) that meant from the outset a methodology could be chosen and aims of the inquiry owned by those who would be participating. Early identification of stakeholder participants ensured that the process was designed and driven by all and changes in participation could be quickly responded to. Chevalier and Buckles (2013) argue that this early identification is crucial to the essence and functioning of a PAR inquiry and bring together five skill sets that together ensure collaboration: mediating, grounding, navigating, scaling and sense making. Through applying elements of these skills to the inquiry the participants were able to quickly engage in a mutually empowering and inclusive process of change.

Contrary to traditional methodologies where research participants are clearly identified and ethical considerations embedded in the study, PAR by its very nature attempts to include participation at both a formal and informal level. The potential sample focused on all stakeholders participating in the development of a dual diagnosis service within the environment of primary and community care; and specifically within the HSE South West Sector of Cork city, Ireland. This area of Togher/Ballyphehane, Cork has a population of 47.580 inhabitants (approx.).

In keeping with Chevalier and Buckles (2013) argument that stakeholders should be named early, the lead researcher engaged with all potential initial stakeholders who then were able to expand the participant pool as the systemic network grew. At the outset, participant stakeholders included practitioners, academics, service users and family members who engage in the referral, assessment, treatment, education and wellbeing of those experiencing dual diagnosis in this sector. The inquiry includes the disciplines of mental health, psychiatry, addiction, psychology, social work, occupational therapy, general practice (GP's), academia and legal/judiciary. The participants became more defined as the service began to evolve and the dialogue enabling process started to bed down once Cycle 1 was under way. Participants included clinicians, GP, service users, family members, counsellors, alternative practitioners and an educationalist.

As an evolving process there is not a specified time period that participation and consent is determined. The PAR process is integral to the evolving system change and by engagement in the service there is default participation. This creates a potential ethical dilemma that had to be

addressed in this as with any other PAR inquiry. Khan *et al.* (2013) argued that ethics "is the ultimate underpinning of research and PAR in particular" considering "the well-being of the individual research subject must take precedence over all other interests" (p. 167).

Ethical approval was granted for the inquiry by the locality clinical research ethics committee. However, ethical approval is only one step in the inquiry process, as according to Boser (2006), ethical considerations need to be integrated into each AR cycle raising awareness of potential risks for participants as decision-making occurs during the process.

The core values of participatory research according to Reason and Bradbury (2008) have been defined as "a participatory, democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes. It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities" (p. 4).

This reflects what Brydon-Miller (2007) refers to as immanent ethics and values that may define the PAR process itself and further guide and evaluate the unfolding inquiry. Reflecting on this as cycle 2 unfolds, a forum for the on-going ethical discussion has started in cycle one and is evolving as a participatory process. In addition, no information, data source or findings are reported upon that refer directly to any individual unless they have given explicit consent for inclusion in the inquiry.

Methods: the transforming process

The first cycle of this inquiry and service development focused on creating the participative process; and informal transformations evolving from the dialogue created in the process, form the basis for formalising aspects of the service already agreed in cycle one. Process outcomes as opposed to quantifiable and measured treatment outcomes were key to demonstrating that such a transformation in the initial cycle had occurred.

However, stakeholders in cycle one have participated in multiple data generation methods including: journaling, informal interviews, planned discussion and focus groups, logs of multi-disciplinary team meetings, testimonials, observations and reflections. This active process has enacted the initial phase of stakeholder engagement and has created a steering forum, which is considering how data will continue to be gathered and analysed in cycle 2. For illustrative purposes excerpts of testimonials will qualify observations made towards the end of cycle 1.

Figure 1 illustrates the anticipated process of transformation and each stage of the cycle will be discussed in the subsequent section.

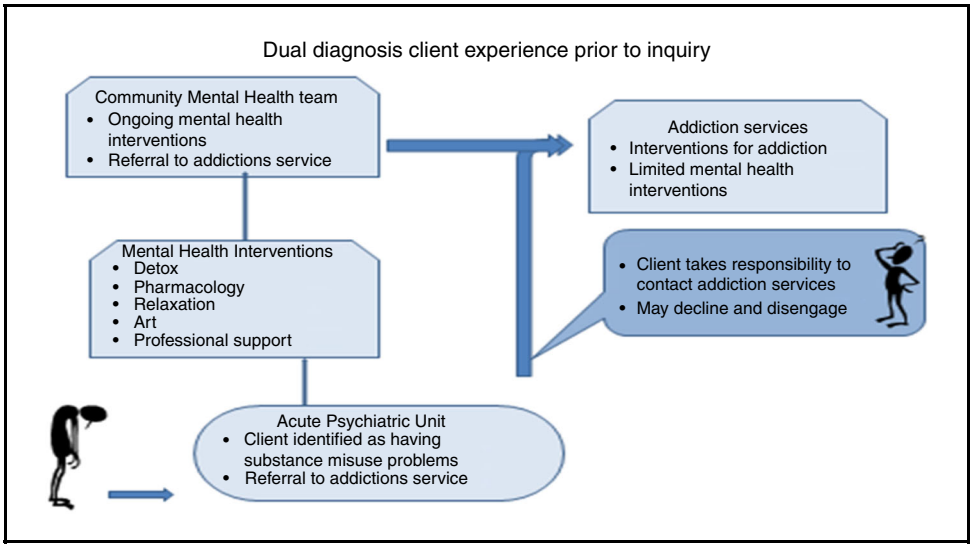
Cycle 1 outcomes

The research cycle provided a systematic process to illuminate the evolving dual diagnosis service. The reality of practice meant that all did not cycle in unison or at the same pace, though all that was planned has been enacted over the course of one and a half years.

Reflection stage

Because of the preceding exploratory and collaborative process (Connolly *et al.*, 2010) a lot of ground work for this stage was already in development. There was already an active group of practitioners from mental health and addiction services engaged in thinking and talking about how to develop the dual diagnosis service. As yet the service response was along the lines of a serial model, see Figure 2 for an example of how clients with possible dual diagnosis would generally receive service provision if they started their journey on the acute psychiatric admission ward. In the participating services there was a commitment to increasing service collaboration and the principal researcher (lead author) was already taking on dual diagnosis clients on an ad hoc basis. There was an impetus for change and an agreement on how to move forward.

Figure 2 Process map A



Planning stage

Crucial to the planning was identifying a dual diagnosis co-ordinator who would bridge the two services and initially take on the role of key worker for clients coming through the referral process. The lead researcher took on this role by agreement with both his employer in addiction services and the management team of the mental health service. His role was to streamline referrals, provide individual clinical intervention and liaise with clients and multidisciplinary teams in relation to needs and treatment options for referred clients.

What was an ad hoc discussion group was expanded as part of stakeholder engagement later becoming the reflective dialogue group that steered the process. This group comprised practitioners working with dual diagnosis clients, service users, and as treatment options expanded professionals from those areas. This group were to provide ongoing reflection, decision making and a mechanism for ongoing adaptation of the inquiry process.

At this stage the steering group agreed to keep the referral process loose and informal until a pathway became evident and patterns identified. In the main where clinicians from either service identified dual diagnosis needs and the client was in agreement, then a referral was to be made directly to the dual diagnosis co-ordinator.

Once referred, clients would undergo assessment with the co-ordinator and where appropriate engage in individual work and/or other treatment options becoming available. They would continue to engage with their clinical teams unless a joint decision was made that this was not necessary.

A range of treatment options were discussed and avenues for utilisation, e.g. grant funding explored. In addition to individual dual diagnosis interventions, such as motivational interviewing and harm minimisation approaches, for the purpose of this paper only two additional options will be reported. These are a dual diagnosis psychotherapy group and acupuncture.

Action stage

It became evident early in this cycle that most of the referrals were coming from the acute psychiatric admission unit, though some still came from community mental health teams and addiction treatment centres. The steering group started to formalise the referral process and built dual diagnosis into their regular assessment.

The dual diagnosis co-ordinator became pivotal in the ongoing liaison process between client, clinical teams and external treatment services. This process was built into the mental health

team meetings where he would attend for a determined time when dual diagnosis clients were being reviewed. Work with dual diagnosis clients dominated his clinical case load and he also facilitated the dual diagnosis psychotherapy group.

The bridging role of the dual diagnosis co-ordinator provides an integrated approach to treatment. In addition, specific dual diagnosis interventions meant that more options became available than if a client was using only the mental health or addiction services. Ironically some of the treatment options were in services already. For example, Art therapy, which clients did not previously access, were more likely to be accessed by them once they were engaged with the dual diagnosis service. The steering group itself was amorphous at times. For example, where several practitioners were involved in mental health services and team meetings, initial decisions were made in relation to referrals that would be later discussed at the wider group meetings. The inherent informality had advantages and disadvantages. Where on one hand decisions could be made in the moment, this may not communicate to the wider stakeholder group and pressure was increased for the co-ordinator to ensure all stakeholders where possible became informed and had the opportunity to contribute.

Observation stage

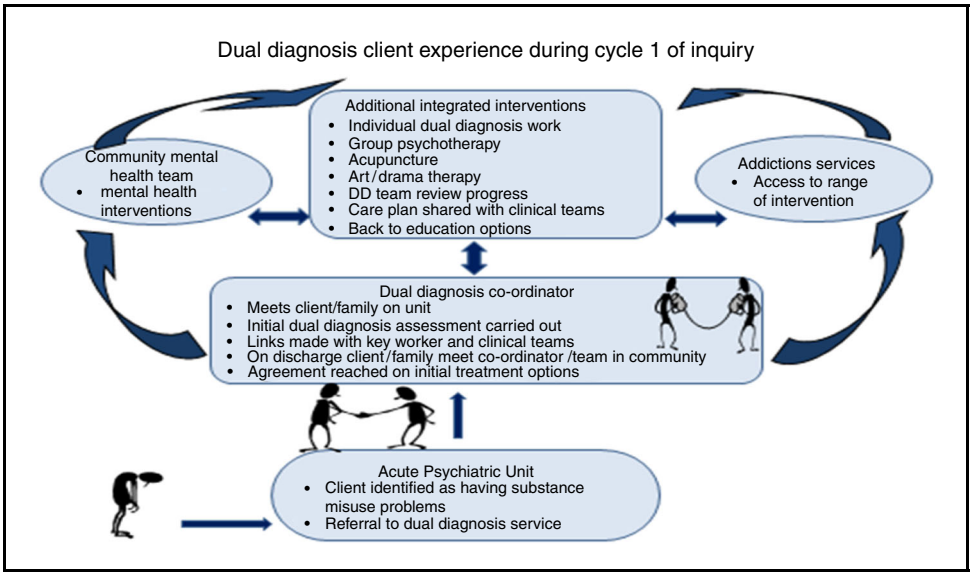
The observation stage identifies the process outcomes so far in this inquiry as cycle 1 moves into cycle 2. The extent of service transformation is evident in the sample process map B Figure 3 illustrating the revised experience of the dual diagnosis client admitted to an acute psychiatric admission unit. Variations of this experience arise depending on where the client referral originates, however, the same process ensues.

Although the service is in flux and not formally bedded down, it now operates as an integrated dual diagnosis service. Three particular process outcomes are presented as those that have helped to transform the practices of two co-existing services into an enhanced integrated service for clients with dual diagnosis.

The first is the introduction of the dual diagnosis co-ordinator who now provides the medium by which the client can engage with an integrated service and who additionally provides dual diagnosis interventions.

The second concerns the development of a dual diagnosis referral process. Stakeholder engagement in cycle one facilitated the initiation of a new informal referral process. For example, the lead researcher/practitioner receives a phone call from the consultant psychiatrist or team

Figure 3 Process map B



member in the acute unit referring a dual diagnosis patient who has been admitted. He will then visit the ward and begin an initial assessment – see Figure 3 (previously this referral was made to the specialist addiction service which is located in a different hospital; the client was put on a waiting list but rarely presented for these appointments). The advantage in initiating the assessment on the ward is that the client establishes a relationship with a member of the community based dual diagnosis team, prior to being discharged. Informal referrals also come from multidisciplinary teams in out-patient settings across the sector to the dual diagnosis service. Client data gathered at the initial assessment phase generally include a referral letter outlining the mental health diagnosis, substance use, current medications, social history, etc.

The third concerns the introduction of two additional intervention options for clients referred to the dual diagnosis service, a psychotherapy group and an acupuncture clinic. Both of these were specifically requested through the steering group, where suggested new services for clients with dual diagnosis are processed. The psychotherapy group was newly introduced and is co-facilitated by the lead researcher and runs once a week in a local community centre. The psychotherapy group can be currently described as active, directive, semi-structured, collaborative, open-ended and on-going (Flores, 2007; Rotgers and Nguyen, 2006; Forsyth, 2009). As indicated previously one of the data collection tools was to ask stakeholders for testimonials relating to their experiences of the evolving service. The following extracts have been purposefully chosen as an illustration of the potential positive impact of the psychotherapy group.

T. was referred to the service with a diagnosis of schizophrenia and poly-substance misuse; he offered this narrative highlighting his benefits from attending group psychotherapy:

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

C. was referred to the service with a diagnosis of severe anxiety and alcohol dependence; he offered this narrative highlighting his benefits from attending group psychotherapy:

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

A further observation in relation to the group was made by the steering group in response to the group evaluation where service users were asked to determine how they wanted the group to go forward. Some group members suggested that a second group ought to be formed which separated those who were regularly using alcohol and illicit substances from those that were not. This information is reviewed at each steering group reflection meeting; however, no further action has been agreed upon or taken as yet.

The other additional intervention introduced to the service was an acupuncture clinic. Although, this was an existing adjunct treatment to clients attending an addiction service in a hospital setting, because dual diagnosis clients would previously not necessarily have engaged with this service, the opportunity for acupuncture was missed. There is the option now for clients to directly access acupuncture with the clinic available four days each week. The following excerpts from client testimonials were purposefully chosen to illustrate positive impact of acupuncture.

P. was referred to the service with a diagnosis of anxiety and alcohol dependence; he offered this narrative highlighting the benefits of acupuncture alone as he declined in cycle one to participate in other activities:

> I had fierce anxiety and drinking a slab of lager every day at home when was referred for acupuncture, I had to be driven to sessions initially because of my anxiety and inability to take the bus. I couldn't go into enclosed areas like the shopping centre. Now, I don't want drink anymore, my anxiety levels are

> good enough for me to live my life and I am back working in a rehabilitation work project scheme, happy days […].

K. was referred to the service with a history of depression, suicidal intent and poly-substance abuse. She offered these narrative highlighting benefits she experienced from attending acupuncture regularly with the objective of reducing drug cravings and improving her sleep pattern:

> I got great support from the people than run the groups, also I started going to acupuncture three times a week. Up to then I was only sleeping two hours at best, after one week's acupuncture I was sleeping more and more. I now sleep naturally for a full eight hours, my depression is much less and the cravings are not there most of the time. It still comes back at times especially when I had a relapse on alcohol, but through the group I have learned how to manage it and cope with it. I have started running, finishing my first ever mini marathon. I now run every day, attend acupuncture regularly, go to the group every week, see my psychiatrist every month and do not take any more medication. I feel as if I can breathe like never before and like a huge cloud is lifted that was always there and I see myself laughing now. I can enjoy taking my son to football and be there for him in a real way […].

Cycle 1 of this inquiry has shown that it is possible to develop an integrated dual diagnosis service in one community by utilising a PAR methodology and already cycle 2 of the inquiry is engaged with developing the service further, embedding developments as sustainable service delivery with specific plans for measuring impact. The following discussion will consider reported outcomes of cycle 1, reflect on the PAR process so far and the implications for this inquiry as service developments merge into cycle 2.

Discussion

Conceptually, dual diagnosis emerges from "the theoretical segregation of mental disorders and substance misuse within commonly used classification systems such as DSM IV (now DSM V) and ICD-10" (McKeown, 2010). The author highlights what cycle 1 of this inquiry has encountered; that many people experiencing what's known as dual diagnosis seem to have multiple clinical and social problems, "so in reality dual diagnosis could be construed as a misleading and over-simplistic concept". Cycle 1 has shown that despite the complexity of dual diagnosis that a service response where sufficient participation and commitment is in place can address people's needs.

PAR methodology is not new to health care and has an established impact on transforming health care practice, service development and reorienting organisational provision (McDaid, 2006; Lazes, 2007; Mac Gabhann, 2008; Mac Gabhann *et al.*, 2010a, b, 2012; Berg-Powers and Allaman, 2012; Watters and Comeau, 2010). This inquiry has enabled dual diagnosis service transformations to occur offering a further contribution to evidence of its effectiveness in health care development. That the cycles of PAR are ongoing will ensure a continuous process of reflective transformation.

One of the crucial elements of success so far in the inquiry has been the ability to develop this service within existing resources that requires some refocusing and a broader engagement with established provider agencies. As the development moves into the next cycle of change there will be some anticipated systemic changes that will require additional resources, for example, formalising referral processes. This brings about new challenges and questions around sustainability of established changes that must be addressed going forward.

There are other challenges to be addressed in cycle 2 particularly in relation to ongoing stakeholder participation in the service evolving and the role of the dual diagnosis coordinator. Considering stakeholder engagement so far, it has moved from a consultative process to more of a collective participation in the methods adopted and the iterative process taking shape. "This articulates action research as an emergent process of engagement with worthwhile practice purposes, through many ways of knowing, in participative and democratic relationships" (Reason, 2006). In one way, the level of participation has moved to a deeper level of participation and impact on the evolving service. Though as the collective participation strengthens, inclusive of the same representative groups of stakeholders, there is also some reduction of engagement by service users in formal participation (i.e. consultation and on steering group). Arguably, part of

their initial engagement has included their receiving a more effective service and it is not unreasonable to suggest that they may have had their needs met and see no reason to remain as participants in the inquiry. Moving into cycle 2, it will be important to discern the extent of engagement of this participant constituency and where this changes to establish where possible why that is the case.

At this stage of the inquiry when a service has been established and the lead researcher enabling this has a pivotal role as dual diagnosis coordinator in the evolving service, their position needs to be reviewed. In addition to other practitioners conducting business as usual albeit with a refocusing of their roles in relation to dual diagnosis. "Insider action researchers need to be aware of how their roles influence how they view their world as well as how they are viewed by others, and to be able to make choices as to when to step into and out of each of the multiple roles they hold" (Coghlan and Brannick, 2010, p. x). The lead researcher has expanded his initial practitioner role extensively in order to establish the dual diagnosis coordinator role. In establishing a sustainable service there are solutions necessary in order to accommodate changing practitioner roles, in particular the dual diagnosis coordinator role and who or what that will be once the research inquiry itself is ready to close.

Some of the key implications for the next cycle in this inquiry are: whether a formal assessment and referral process can be embedded in the evolving service; that resources can be found to meet the next level of development; and if the formalised service can develop outcome indicators that will demonstrate clients are receiving a comprehensive dual diagnosis service. Moreover, now that dual diagnosis is visible and being responded to, how well prepared are professionals and service users to engage with a dual diagnosis service? Participants have requested the role and need for education, training and supervision in working with mental health and substance misuse. Exploring the implementation of clinical guidelines for working in this context, Hughes (2011) signals that "all professionals should have access to evidence based education and training" and further critically highlights that "Supervision ensures safe and effective practice in line with appropriate clinical guidance". Cycle 2 must consider this as part of the process of embedding a sustainable service.

Conclusion

Implementing cycle 1 of this inquiry has secured the initial engagement of many stakeholders and consequent service transformations have begun to unfold as illustrated in Figure 3. Examples described in "Cycle outcomes" above, provide new practical resources for stakeholders and the general dual diagnosis population in this sector and new practical knowledge which informs future cycles in the inquiry. This practical knowledge has emerged through the cyclical and participatory processes of reflection, planning; action and observation.

Though challenges currently exist, the process so far signifies the evolution of a creative space where service users and practitioners can participate in developing their dual diagnosis service. An alternative choice of methodology may not have facilitated this eclectic and participative approach to both service transformation and the potential flourishing of those experiencing dual diagnosis in this community.

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Corresponding author

John Connolly can be contacted at: johnc.eap@gmail.com