‘They don’t actually join the dots’: An exploration of organizational change in Irish opiate community treatment services

Abstract

Background: People who use community-based drug treatment services spend a considerable amount of their time in treatment in direct contact with frontline staff. These staff are also fundamental to supporting the implementation of change to meet service user needs. Yet, very little is known about staff perspectives on the process and internal dynamics of drug treatment services, their views about what makes services work effectively, and how services can more effectively adopt to changes in practice.

Aim and Method: Conducted across Irish community opiate prescribing services and drawing on data from 12 in-depth qualitative interviews with frontline staff. This paper examines the narratives of staff about the factors which influence the dynamics and process of treatment services, particularly in relation to the implantation of change.

Findings: Change *itself* was described both in respect of how a service responded to immediate service user needs *or* supported planned change. Little distinction was made in respect of service attributes which facilitated a response in either context. Overwhelmingly, staff contextualised current service effectiveness, historical change, and desired change in how effectively their services met service user needs, which was also viewed as a significant motivation for change. Differences in operational standards across services in terms of practices, policy implementation, job roles, divisions between professional groups, and recruitment and retention of staff inhibited change adoption. Factors which were identified in terms of inhibiting or facilitating planned change were consistent with the wider literature on change implementation but provided unique insights in the context of substance misuse services.

Conclusions: A range of interdependent factors which influence an ‘eco-system’ of service delivery were identified. Effective policy implementation in Ireland remains aspirational, but findings reported

in this paper have important implications for future planning and design of services for people who use drugs, and provide a good basis for further investigation.

1. Introduction

If treatment services for people who use drugs are to maintain or improve how they meet the dynamic needs of people who are dependent on opiates, they must rapidly adopt to immediate needs, new approaches and technologies, as well as develop a proficiency in working with a multitude of different agencies (Kelly, Hegarty, Barry, Dyer, & Horgan, 2017). From an organizational perspective, we know that some treatment services are better than others at providing treatment, where more effective services yield better outcomes for service users such as increased levels of psycho-social functioning, and reductions in drug use (Greener, Joe, Simpson, Rowan-Szal, & Lehman, 2007). While it is known *that* treatment for people who use drugs works, very little is known about the process and dynamics of treatment services which explain *how* and *why* they work, or effectively adopt to the changing needs of people who use drugs.

It is likely that the effectiveness of treatment relates to a multitude of factors, which are both internal and external to a treatment service. For example, factors which are internal to a service such as staff turnover, burnout, resources, climate, culture and leadership are likely to have an impact on the internal service dynamics and treatment effectiveness (Landrum, Knight, & Flynn, 2012; Skinner & Roche, 2021). External factors such as the development and implementation of policy, or its ideological underpinnings are other factors which are thought to be particularly pertinent in term of their impact on the effectiveness of treatment of drug dependence (Duke & Thom, 2014; Mayock & Butler, 2021b). The nature or extent of these relationships and how they impact on treatment remains unclear.

There is no one 'over-arching' theory which can simultaneously describe how organizations and change within those organizations works. There are however a range of seminal theories and concepts which can help our understanding of how organizations work and are relevant for underpinning practice-based change and research design. For example, systems theories describe organizations as a collection of individual components where examination of a singular phenomena fail to encapsulate whole interdependent systems and sub-systems (Orton & Weick, 1990; Von Bertalanffy, 2013). This suggests that we should consider events in organizations as having multiple causation and that change can only occur by changing a system and not just its individual parts. Consideration of the *drivers of change* (e.g. economic, technological) and *types of change* (e.g. planned, unplanned, big or small) are also thought to be important in terms of understanding *how* organizations and change work (Crowther & Green, 2004; Porras & Robertson, 1992). Within seminal organizational change theories and where measurements of change have been operationalised in practice, change is interpreted as a multi-stage, non-linear process and not just a 'once-off' event (Lewin, 1958; Louie, Barrett, Baillie, Haber, & Morley, 2021). From these theories, we can deduce with some certainty, that organizations are complex 'eco-systems' where the specific characteristics of organizations are influenced by a plethora of overlapping and interdependent factors.

While a number of conceptual approaches related to organizational structure and organizational change were considered relevant, the concept of *organizational readiness to change* (ORC) was considered to provide an appropriate conceptual guide for this study. ORC, a multi-level construct, is a key concept with the field of organizational development and is described as a shared psychological construct of how *willing* and *able* staff are to support organizational change (Weiner, 2009). Theoretically at least, ORC is influenced by a plethora of determinants such as the nature of a specific change, and a range of contextual and informational factors which are internal and external to an organization (Holt & Vardaman, 2013; Weiner, 2009). In practice however, two systematic reviews on ORC which included over 20 studies, mainly conducted in U.S. addiction treatment services,

determined that where ORC has been operationalised or measured it has most typically not incorporated a specific change, but has been used more as a measure of overall organizational functioning (Kelly, Hegarty, Barry, Dyer, & Horgan, 2018; Kelly et al., 2017). Studies included in these reviews have identified that staff perceptions of; specific types of organizational resources such as staffing, aspects of organizational climate such as communication and openness to change and staff attributes such as having influence with peers and more job autonomy, can make services more effective at both innovation adoption and engaging service users (Lehman, Becan, Joe, Knight, & Flynn, 2012; Simpson & Dansereau, 2007). While relationships between ORC, change adoption and client engagement were established in many of these studies, the mechanisms which underpinned these relationships remained unexplored, and there is a dearth of prospective, interventional studies, or qualitative exploration which facilitated retrospective analysis (Kelly et al., 2017).

Overall, the evidence on how substance misuse services work is characterised by a deficit in knowledge of what organizational and workforce attributes make a service more effective adopting to change and at delivering treatment (Louie et al., 2021; Van de Ven, Ritter, & Roche, 2020). The complexity involved in identifying factors which influence a services ability to adopt to change or its treatment effectiveness may be one reason why this question has not received appropriate levels of attention. The availability of resources, incentives for researchers, and methodological challenges are also likely to play a part (Bauer, Damschroder, Hagedorn, Smith, & Kilbourne, 2015; Kelly et al., 2018). In the absence of large scale and resource rich studies, qualitative inquiry is an appropriate approach as it will allow for retrospective inquiry and can provide insights into how social and cultural and organizational phenomena impact on respondents and their perceptions of service functioning (Flick, 2018; Foss & Ellefsen, 2002).

2. Method

This qualitative research focused on exploring staff perspectives of organizational functioning and change in community opiate prescribing services in Ireland. Specifically, this research was focused on what factors might influence a services effectiveness at adopting to change. A qualitative descriptive approach was used as this is thought to be particularly useful for research in healthcare through the provision of rich, straightforward and factual explanations for different perspectives on the same phenomena (Colorafi & Evans, 2016; Neergaard, Olesen, Andersen, & Sondergaard, 2009). Ethical approval was granted for this study from two regional ethics committees in Ireland. For this study, services were considered separate when they operated from different buildings only.

2.1 Recruitment

Participants were recruited from a convenience sample of 12 [seven urban and four rural] publicly funded community opiate substitute prescribing clinics in Ireland using a purposive sampling approach (Etikan, Musa, & Alkassim, 2016). Services were identified through a combination of internet searching, consultation with regional managers of addiction services and through a wide range of consultations with members of bodies representing professionals such as psychiatrists and nurses. Permission to access services was obtained directly from service managers, all staff teams were emailed with details of the study and in most cases the researcher met with the multi-disciplinary teams in person, answer any questions about the study, and to identify suitable participants. Although there is no national registry of addiction services or prescribing services in Ireland, it is estimated that the clinic sample represents approximately 40% of all such clinics nationally. All 12 clinics that were approached, agreed to participate in the study on the basis that their anonymity would be assured.

To be eligible for participation, staff had to be over 18, have direct contact with service users and have worked or volunteered in individual OST services for more than 14 hours a week for a period no less than one month. Within these confines, effort was made to recruit participants from a range of professional backgrounds, subject to their availability in busy clinical environments. Data adequacy was considered by the research team in terms of the study design, composition and number included in the sample, but also the depth or *richness* of the data required from each participant (Vasileiou, Barnett, Thorpe, & Young, 2018). Based on this, *thematic saturation* was considered as an appropriate means to justify sample size (Fusch & Ness, 2015). Thematic saturation was considered to have been reached after 10 participants and considering the study design, study objectives and phenomena under investigation, the decision to include 12 participants was deemed to be appropriate (Alder P & Alder PA, 2012; Baker, Edwards, & Doidge, 2012). The 12 staff represented three quarters of staff approached to participate throughout the course of this study.

2.2 Interview procedure and data collection

A number of different interview approaches were considered for this study (Mitchell, 2015). The semi-structured interview design was considered most appropriate and its design and implementation followed a five-step process described by Kallio, Pietilä, Johnson, and Kangasniemi (2016). (i) Pre-requisites for using semi-structured interviews were considered; a semi-structured interview guide was used as this was considered appropriate for participants to openly explore their experiences and provide a lucid description of the constructs under discussion (Mitchell, 2015; Sandelowski, 2000; Watson, McKenna, Cowman, & Keady, 2008). (ii) Previous knowledge was assessed examining important concepts, and findings from two systematic reviews on organizational readiness to change in addiction treatment services were considered (Kelly et al., 2018; Kelly et al., 2017; Weiner, 2009) and (iii) A preliminary interview guide was formulated on this basis (iv) A pilot study was conducted (n=2) before (v) the semi-structured interview schedule was deemed appropriate. When recruiting,

staff were approached individually, and subsequently interviewed in a quiet room in their places of work. Following the provision of an information leaflet, an opportunity was given for participants to ask questions about the study before the administration of consent form which was signed by all participants. To develop a sample overview, demographic data, which was pseudo-anonymised, was collected.

In order to encourage participant comfort, all interviews commenced with a question about the persons career to that point. Subsequently, several areas relating to organizational functioning were targeted in the discussion relating to what works well in the organization, how the service helps service users, how effectively the service adopted to change, what facilitated this change (or not), what could be improved and how (Appendix 1). While the interview focused on specific topics, a flexible approach was used by the interviewer in order to allow participants to identify salient topics and talk openly (Silverman, 2013). This helped to maintain focus on the important experiences of working in services. Interviews lasted between 1 hour and 1 hour 25 mins. Data was collected between July 2019 and March 2020.

2.3 Data management and analysis

Trustworthiness was carefully considered throughout this study including at the design stage (Elo et al., 2014; Thomas & Magilvy, 2011). Interviews were transcribed verbatim, but with all personal identifiers removed and the text was cross checked for accuracy. Analysis was guided using a content analysis approach as this is considered the most appropriate type of analysis where a qualitative descriptive approach is used, and it is also considered a most suitable approach for organizational research (Duriau, Reger, & Pfarrer, 2007; Sandelowski, 2000). Considering the study objectives and the need to provide *rich* information, using a *latent* approach to data analysis was considered acceptable and appropriate (Bengtsson, 2016; Graneheim, Lindgren, & Lundman, 2017). Analysis was

guided specifically using a step by step process for content analysis described by Erlingsson and Brysiewicz (2017). Firstly, the content of the interviews was analysed by the researcher (PK) reading and re-reading the data in order familiarise with the text and identify emerging categories and themes. Meaning units were developed and then through an iterative process involving cross-checking and discussion with the research team (PK,AH,JH). These three researchers initially reviewed six transcripts and met at various intervals to reconcile a list of codes that captured all of the relevant data. Subsequent interviews were then coded by one researcher (PK) and new codes were developed if or when required. These codes, were then condensed into sub-categories, categories and finally themes using an inductive process where the team met at regular intervals to develop consensus and ensure consistency across all of the interviews (Erlingsson & Brysiewicz, 2017; Yates & Leggett, 2016). All members of the research team (PK,AH,JH,KD) had previously attended training courses in qualitative research which incorporated techniques on how to best account for their subjectivity. A reflexive approach was taken throughout the process through the use of a reflective diary by the primary researcher (PK). This approach was not undertaken from a firm philosophical standpoint, but in order to account for the primary researchers position or impact on the research process (Dowling, 2006; Jootun, McGhee, & Marland, 2009). The reflexive diary took account of reflections on each service visited, the interview process, the dynamic between interviewers and interviewees and laterally to take account of sources of bias in the interpretation of data. Reflections were discussed with the research team during all group meetings (Dowling, 2006).

3 Results

3.1 Participant and service characteristics

The study cohort were interviewed across 10 different geographic locations in southern Ireland at their places of work. Four of the interview participants worked across several services under the same management structures. All participants worked in prescribing services with multi-disciplinary teams comprising mainly of both permanent and sessional prescribers, nurses, counsellors, psychologists,

social workers, drug workers and general assistants. Sessional prescribers were typically non-addiction specialist General Practitioners (GP'S) working in their own practices, who attended OST-services for once or twice a week 'clinics' to prescribe opiate substitution therapy and briefly review service users. Interviewees came from a medical or nursing background (n=4), a counselling or psychology background (n=5) or worked as drug workers/general assistants (n=3). The seven women and five men were predominantly white Irish, had a mean age of 49, had been in their posts for longer than five years and were educated to either degree (n=9), masters (n=3) or PhD (n=1) level.

3.2 Findings

During interviews, all participants discussed their services ability to adopt to change in two related contexts; responding to more immediate service user needs, and implementing specific innovations across the service, such as new therapies, physical health interventions or changing the physical environment. Generally, participants referred to a service in terms of being in one building, but participants who worked in more than one area, or across buildings, typically discussed the service in that context. Three inter-related themes arose from the data (Table 1). The themes were articulated as three distinct needs i.e., need to (i) Meet people where they are at (ii) join up the dots (iii) get buy in (for change initiatives)

Table 1: Summary of findings from qualitative interviews; themes and sub-themes

Theme 1: 'Meeting people where they are at'
How the service meets service user needs; meeting needs as a driver of organizational change; where we have come from-'shifting the balance' and meeting service user's where they're at; how the service needs to change to meet service user needs.
Theme 2: 'We need to Join up the dots'
Inconsistencies in how individual staff and staff groups operate; operational differences within and between services; how recruitment and retention impact on change adoption/service delivery.
Theme 3: Getting 'buy-in'
Organizational attributes and attributes of change which support or inhibit change implementation; ensuring stakeholder buy in, ensuring measurement or 'follow through', risk aversion and lack of resources impeding change.

'Meeting people where they are at'

Staff identified that service users in OST treatment have a plethora of complex needs which might be described as existing on a 'spectrum of need'. Drivers of significant changes to the services over time, how current levels of service effectiveness were measured, and aspirations or motives for future changes were all described in the context of needing to 'meet people where they are at' at all points on this 'spectrum'. In this regard, it was universally expressed that both staff and services were on a journey which was not yet complete.

How the service meets service user needs

All interviewees focused strongly on the relational aspect of care. Being warm, empathetic and non-judgemental were seeing as being important personal traits for staff. Interviewees, held largely positive views of their services in respect of using limited resources well, meeting service user needs and relationships between staff and with service users. There was a widely held view that services were overly focused on the prescribing of OST and testing of urine samples, to the detriment of psycho-social and other aspects of care:

"It's very medicalised, I feel. Very medicalised. And so the whole culture of that is about my prescription and you know, and the other elements, which we do try to, I suppose, encourage people to partake in, you know, whether it's counselling or whether it's group work or even just looking at training. All of that kind of takes a back seat in a way to that really important event."

Most staff supported the idea that their services were good at adopting to change and that staff were willing to 'go the extra mile' for service users. In order for service users to access holistic care, having diversity in skill mix, good relationships between staff and having staff with greater levels of experience was considered to be important:

"I do think it's very patient or client-centred and accessible in my opinion …..we have good relationships as a team...with the range of professionals who are working in the clinic. There's a good, rounded service provided, in my opinion"

"I suppose we'd meet, we meet, I won't say everybody does, but I think a lot of people meet clients' needs. We meet the client where they are themselves"

Improved collaboration with outside agencies was considered to be highly important by staff in terms of meeting service user needs. All participants reported some progress in this, but this was inconsistent across services. Specific examples of integrated working included; developing a shared treatment model with mental health services for working with dual diagnosis, to developing a multi-service confidentiality/consent form:

"So that's a really good piece as well because not only are we getting to do a significantly important I suppose joint piece of work around this person, we're also getting to know so many more people out in the, be it the homeless service, be it the accommodation, you know, all the different services, the detox units, you know, the recovery units, that they're all coming in and that I suppose we're open for business."

Meeting service user needs as a driver of organizational change

Participants felts that volume and complexity of cases had increased over time and staff said that they were also expected to 'do more' to address this. The success or failure of services to adopt to change was discussed by all staff in terms of how successfully services improved how they met service user needs or not. Having good communication and relationships with services users in this respect was seen as imperative in order to change service responses to meet their needs. Understanding and needing to respond to a wide range of service user needs, was seen as a significant motivation for

changing practice and services. These changes related to areas such as or supporting service users in their difficulties when interacting with a range of other services, for example legal, housing, or other treatment services or responding to emerging drug trends:

"we do change [practice], I think, when they come in and tell us. Yes. I think they're open as well at telling us about new drugs and that, do you know."

"Yes, we are all adults and we are not doing it for our own ego's or anything like that, we are doing it for the service, and we are doing it for the people we work for [service users]*."*

Where we have come from; 'shifting the balance' and 'meeting service user's where they're at'

Participants described a transition in the ethos of services over the previous decade or more, from that of an abstinence based and ideologically driven approach, to what was described as more person-centred 'compassionate pragmatism'. This involved a shifting emphasis towards the use of scientific evidence and a more harm reduction approach. Services in the past were described as being less accessible and more limited in terms of what they offered service users, specifically in terms of the range of psycho-social supports available, and in respect of flexibility around substitute prescribing regimes. Much of this 'status-quo' was attributed to staff factors such as; training limitations, groups of staff working in 'silos', and the ideological disposition of staff:

"I suppose the thing that I've noticed the most is when I first came to work here, there was more emphasis on the disease model and we've moved away from that and we'd be much more pragmatic in our approaches and I would say that most of the teams have embraced the harm reduction model"

Staff also described their own sense of dissatisfaction with this 'old' ideology and its limitations in meeting service user needs, as one of many motivating factors for wanting to change it. Services in

the past were described as being 'punitive', with one participant using the metaphor of the service constantly 'wrestling' with service users. It was identified that this was still a work in progress as not all staff and practices fitted with this 'new way of working' and that the system still makes people feel 'controlled'. Almost all staff were disparaging towards the 'old way' of doing things:

"The treatment of addiction has been blighted by people dogmatically following an ideologically based approach rather than a pragmatic empathic compassionate based approach."

No specific event or decision was identified in terms of driving this change in ideology. Leadership and a greater divergence in staff skillsets were thought to be a positive contributory factor. Some participants identified the drivers behind this change as being part of a wider societal trend or 'cultural' shift where drug users were being viewed with increasing compassion which influenced national drug policy and was reflected in 'conversations' that began happening in the clinics:

"I think there's also been like a greater focus on the organization shying away from kind of an authoritarian sort of approach to kind of treatment and how the place is run to more of a client-focused… And I can't kind of say specifics, but there would be a kind of focus on the person rather than the kind of rules of the organization. Yes, yes, yes."

Participants described specific changes across services which exemplified this 'shift' in service ethos. Some of these were described as being 'traumatic' to the point that some staff left their posts. These changes included; building purpose-built clinics, changes to the lay-out of existing clinics, changes to practice, significant collaborations with other agencies or in some cases changing entire service models, described by one participant as:

"Moving from a sense of the professionals care plan to a rehabilitatory philosophy of 'it's the clients care plan, and we are the public servants who are supporting and empowering the clients care plan'".

It was thought that 'shifting in the balance' benefitted service users by 'sending them a message that they are valued', delivering a more holistic service, and focusing less on drug use as a measure of treatment success. Within teams, it was generally reported that there is now more focus on evidence-based practice, clearer service goals, and increased communication amongst teams through collaborative working.

How the service needs to change to meet service user needs

Aspirations for change related directly to meeting service user needs and related to either operational aspects of services or resources. Better psycho-social support for mental health issues and navigating through a range of services was expressed as a priority. Many staff suggested recruiting outreach staff or recruiting a lead addiction psychiatrist to accomplish this. It was also felt that cost-neutral changes to the operation of nurses and prescribers could increase engagement and reduce waiting times, [4-6 months in some areas], but this was impeded by organizational structures:

"If we just did things better, more efficiently, you know, and utilised, you know, all of the staff that we have, we could save them a bit of money. So we should be. That should be a no-brainer for people…….I think the hierarchical system that we're in makes it very, very difficult"

Having better access to in-patient services such as detox, stabilisation and rehab was also considered to be a priority. Appropriate physical infrastructure was also considered to be important for safety, particularly in wating areas, and would also indicate to service users that they are valued:

"We're thrown into an old unit and they're coming up to us and I think it'd be more suitable to the clients if we did have kind of a proper purpose-built unit. It would show them they're kind of valued…"

'We need to join up the dots'

Staff overwhelmingly expressed that there was a lack of 'standardisation' with treatment services and between services. This related to differences in practice of staff in the same or similar roles, differences between how staff groups within the same service operated when dealing with service users, or significant operational differences between OST services and external services, this included other OST services under the same management structures. It was felt for a range of reasons, that deficits in 'standardisation' resulted in difficulties retaining staff and obstructed successful implementation of change and/or the services ability to meet service user needs.

Inconsistencies in how individuals and staff groups operate

Multi-disciplinary clinical meetings were seen as a place where staff could exchange ideas and challenge and improve practice. Not all services held clinical meetings with all disciplines present and there was a sense that this inhibited the ability to respond to needs:

"[counsellors have their meetings] *and then doctors, nurses and the managers have their meetings. So I think everyone needs to kind of come under the same umbrella for it to work properly"*

Apart from two services, participants across disciplines observed that there were significant differences in prescribing practices within services, ranging from punitive to lenient. These differences related to how closely prescribers followed OST guidelines for taking urine samples, drug use, and take-away methadone. This had a detrimental impact on how consistently the service was delivered:

"It has a big impact on those [service users] because they receive totally two different services, and we see it!"

Some of this was attributed to the use of sessional prescribers, and differences in how prescribers responded to risk, as well as ideological differences about addiction, such as subscription to abstinence-based approaches or morally-based standpoints. The use of full-time prescribers in services was described by one prescriber as an 'oddity'. These differences communicated a sense of inequity to service users, resulting in inter-personal conflict which support staff have to manage:

"Now, some [prescribers] *are very good and will listen and, you know will kind of be aware of policy, will be aware of good practice and there may be others who don't and it's kind of 'This is the way we do it and that's it', which can be very difficult with service users."*

Some participants described an informal division in teams between clinical (nursing/medical) and therapy staff where these teams often had separate meetings. It was perceived that these groups set boundaries differently with service users. Clinical staff reported having less time to spend with service users and referred to themselves as being a little 'harsher' than therapeutic staff:

"And they're more therapeutic and we're more medical and we're more black-and-white and they'd be a little bit more flexible, I think, with stuff."

Some participants observed that therapy staff received in-house and external supervision or 'lots of maintenance' while clinical staff rely on more informal support. A desire was expressed to have these professional structures in place for all workers as it was useful for reflection on the implementation of more 'nuanced' training and new practices, as well as emotional support:

"Supervision isn't done out in the [place omitted], but like it really, really works, I think, to help you work through problems when you're in this. You want to bounce things off and say, 'Did I do that right? Did I do it wrong? Or what do you think of that?'

"They [counsellors] would have outside supervision. They would have one-to-one supervision with seniors, whereas on the medical side of the house, we're like who's got the time for that? Ok? And then I suppose people are having conversations and it's like the grass is greener on the other side of the fence. So like ok, they're getting that. Why can we not do that?"

Team cohesion was also thought to be adversely affected by differences in how staff adhered to their role boundaries and implemented team decisions. This impacted negatively on how the service met service user needs by sending them 'mixed-messages'. Conversely, staff working at frontline level spoke about being excluded from team meetings, having to step outside the boundaries of their roles to meet service user needs, and expressed frustration as they felt that their skills were not recognised:

"So most of the work, we're like key workers. We're on the ground. We're getting stuff done. We're giving them advice. We're telling them where to go. So we have so many skills, but not utilised."

Operational differences within and between services

Differences were observed in how services within the same management and governance structures operated, particularly where staff worked across several services. The differences identified related to clinical leadership, skill mix of staff, the number of clinic opening days, level of prescribing cover, level or type of psycho-social support available to service users, approaches to risk management, and adherence to protocols. It was identified that these service structures presented barriers against implementing change and a strong desire was expressed for standardisation across services:

"*We're supposed to be all working from the same protocols and the same policies and we're not, we do things very, very differently…. so then that can cause different language, different discussions, how we see a client and work with a client differently"*

One participant attributed this to how services were structured from a 'macro' perspective, in terms of how policy was implemented and how services were planned and developed:

"A lot of the services came into being because the need was recognised first and they put the service in without really thinking more broadly about the structures of those services….it is a bit of a battle from that point of view, trying to bring about change and to influence change- because of the way the services are structured"

From an organizational perspective, factors that were identified as working against change were; rigid staff hierarchies, role entrenchment, not having clear clinical leadership structures, inconsistencies in implementing standard operating procedures or policies, and not addressing poor performance of staff. Many staff spoke about this as being reflected in an overall culture which extended more widely into the health service and government, where it was felt planning and accountability could be improved:

"To say, 'Yes, we did get it wrong' or… And at times, I suppose we see this right up to the political level, don't we? Where we're looking at a statement being made only the other day, 'We got it wrong, we're really sorry'. How long did it take that apology to come?"

The importance of leadership was emphasised in terms of improving services' internal structures, the development and implementation of national policy, as well as streamlining processes between different community services. While staff generally reported that improvements had been made in

respect of integrated work with other services, this was still considered to be a 'work in progress' that needed greater direction, planning and more connection with and recognition of events on the ground from policy makers and planners:

"I think that's somewhere where up along the line, they don't actually join the dots and then it leads to frustration down along the line where people are trying to join the dots, are trying to get people into services, moving along, getting the next stage…get them healthier or whatever and sometimes the dots aren't joined."

As well as needing to improve the planning and integration of services more broadly, it was thought that increasing the standardisation of how services operated would address many of these issues and ensure more continuity of care. It was felt that this would reduce an over reliance on individual staff members, thus increasing equity and consistency of care for service users. It was also thought that improving governance would allow services to feel more comfortable in taking positive risks, both in adopting structural change and in responding to service user needs. Staff who worked in other areas spoke about their experiences of different governance structures and the impact that these structures had on ability to adopt to change and meet service user needs:

"I can see a difference because I came from working with [name withheld] *and the governance structures were really clear. The leads were really clear and so it was a lot easier to look at change and to look at best practice, and to kind of work"*

Several staff felt that oversight and monitoring would be important for improving standardisation in terms of both individual and organizational performance. Staff identified several frameworks such which could be used to 'benchmark' service standards and suggested that these could be monitored

by means of internal clinical audit or through external regulation, the latter is not currently a feature of addiction services in Ireland:

"There was supposed to be this QuADS, which was Quality for Alcohol and Drug Services, and they were going to be like, my understanding, An Bord Failte [Irish tourist board], where they come and you get three stars, four stars. You know, that sort of thing. I think we need HIQA [independent health inspector] to come in and say, 'Why don't you have a safety statement? That's against the law'"

How recruitment and retention impact on change adoption and service delivery

Difficulties in recruiting and retaining staff were identified as something which adversely affected an organization's ability to sustain organizational change and respond to service user needs. It was identified that the principal reasons for staff leaving were related to lack of career progression and better opportunities to progress in other specialist areas. In smaller clinics, staff identified negative impact on service users when clinical staff were not available, such as non-attendance at clinics and increased waiting times for assessments. It was felt that a 'standardisation' of job roles career pathways and processes within clinics, as in other specialist areas of healthcare, would help to address this and support change implementation.

"Well, without that [standardisation], *you see, you're going to have a throughput of staff and that's a problem. You know, that's a problem because I think you're not going to develop things unless you maintain your experienced staff. You'd be retraining everybody all the time, so I think that's across all services."*

Working within the addictions field was not seen as an attractive prospect for outside healthcare professionals. In general, staff identified that the work was 'emotionally challenging, exciting & wearing', with service users 'bringing in heavy stuff' and making slow progress in treatment. Several

staff members reported dealing with the deaths of service users in the past year. This necessitated utilising informal supports from colleagues and giving attention to self-care outside of working hours. Many staff also suggested that increasing staff resources, and in some areas using existing resources more effectively would help to address this. Some staff felt that rewarding staff and having informal gatherings either inside or outside the working environment would benefit the team dynamic and help to alleviate the risk of burnout. Again, formal supervision was also identified as providing important emotional support and reducing burnout but was not available to all staff.

"*A lot of the time, you wouldn't see faster recoveries and outcomes like and you can get burned out from that, do you know. But I think when you have supervision and someone to talk to, it kind of stops that burn-out, do you know."*

'Getting buy-in' – facilitators or inhibitors of change

Staff discussed factors which facilitated or inhibited specific changes. The types of changes ranged from the implementation of training, change involving significant resources and multi-level 'buy-in', or both. Organizational change sometimes involved the implementation of specific types of training. Most changes described were designed and implemented based on local needs, but some changes to practice were part of national initiatives. Some staff identified that a changes which made their job easier were more likely to be supported, but overwhelmingly described meeting service user needs as a significant change driver. Staff generally described that they had frequent exposure to training and all staff except one, identified that their organizations frequently discussed and implemented change. Most staff described increasing confidence over time in their organizations ability to change, based on a history of successful change implementation:

"Do you know, if you'd asked me four years ago when I was much more cynical, I would have said no chance, but if I sit back and I reflect on what's happened, there's been huge changes. Huge changes."

Ensuring stakeholder 'buy-in'

Service managers were seen as being key 'stakeholders' in driving and supporting change due to their influence on the operational aspects of services. Managers were thought to be important in facilitating vital components of a successful 'change-culture' such as clear communication, consultation, increasing transparency and helping staff to 'know why' a change was important. Facilitating regular staff meetings, which were open to all staff and disciplines, and where change and new ideas were discussed frequently were viewed as being important. General approaches, such as having an 'open-door' policy, considering new ideas from staff, having an inclusive leadership style, bringing in new ideas regularly from training and conferences were considered as change facilitators. Obtaining support from managers or senior clinicians was seen as fundamental aspect of getting 'buy-in' which was considered imperative for the successful implementation of change:

[the change would work] "So as long as I had a consultant [specialism withheld] *who was on board, a couple of* [specialism of nurses withheld] *who were on board and myself and the director and the doctors here"*

There was no evidence of any services or change being fully co-produced with service users, but increasing professional stake-holders belief in the potential success of a change was considered to be important. In practice, this was accomplished through implementing a small scale 'pilot' for a change, or by finding examples in other services where the change had been successful. Staff used a mixture of drawing on experiences of working in other services, conducting pilot initiatives, or obtaining detailed evidence from other services on their successful initiatives:

"So that was a huge, huge part of bringing the service to them [service users] and because it was done in another drug service, we knew it worked, that model."

Ensuring measurement or 'follow through'

All successful changes were characterised by measurement or appraisal of the impact of the change, described by one staff member as 'follow through'. Conversely, in most cases where unsuccessful change was described, having no appraisal process in place was seen as a fundamental reason why the change failed. Internal audit and/or research and implementing mechanisms where this information could be disseminated to staff, were provided as examples of how the impact of change could be measured and sustained. In one case, an audit revealed that target for a life-saving initiative were not being reached, and this finding increased conscientiousness amongst the team for many other areas of practice:

[clinical audit] *"I think so, I think so because I think if you can't monitor a change, then there's no point."*

Clinical supervision was also identified by several staff as something which facilitated the implementation of of new ideas and/or training, particularly for more 'nuanced' work, for example that involved in child protection cases and in implementing structured psycho-social interventions such as motivational interviewing or CBT.

"*But like it* [supervision] *really, really works, I think, to help you work through problems when you're in this. You want to bounce things off and say, 'Did I do that right? Did I do it wrong? Or what do you think of that?' I think it's really, really good like."*

While most staff were considered to be positively disposed towards change, specific attributes of staff were seen as a factor which worked for and against change implementation. Staff attributes that

mitigated against change were identified as having a negative ideological view of addiction, role entrenchment or the personality of the individuals. In terms of changing the service ethos from abstinence to 'compassionate pragmatism', bringing in new staff and staff with these 'negative' traits leaving as well as the opposing ideologies of these staff was seen as a vital catalyst for successful change:

"We did have one or two individuals who were not for moving, but they did move because that [change] was happening and you know, one person in particular decided this was no longer for them here, you know, but there was nothing we could do about that."

However, there was an acceptance that there would always be some staff that would be opposed to change no matter what. It was considered that while not without difficulty, these staff would be encouraged to change through the 'momentum' of other staff embracing the change:

"I often think of the chain on a bicycle, once it starts to move, it's all systems move, you know. The momentum is there. They have to, and if a cog gives, it gives. But the system will have to override it, do you know. It has to override it and that's the difficult bit."

Risk aversion and lack of resources impeding change

Several staff reported that having knowledge that resources and training would be provided for supporting a change over a time period increased their belief and enthusiasm for supporting change, and also resulted in successful implementation. Poor staff resources in terms of numbers of staff and skill mix, was another factor which worked against change. In one case it was considered impossible to introduce a new drug for OST as it required daily clinical review of a service user and the resources were not available to do this:

"But in some places, the cover is very sketchy, you know, and it changes a lot and I think that reflects the… I suppose I'm not talking about the general service now. I suppose I'm talking about the medical part of it. It just really reflects the state that it's at at the moment, you know. And that's how it is."

Fear of litigation and fear of risk was also seen as another factor which mitigated against change. This observation was made by several staff. This was noted more specifically around embracing a more harm reduction approach and around changing prescribing practices.

"There's so much red tape. I'll tell you, it's fear of litigation. I have never worked in an area that's so fearful."

4. Discussion

Findings form this study demonstrate that organizational efficacy is influenced by a multitude of interdependent factors, which are both internal and external to the organization. In the first theme, a services ability to meet user needs was clearly identified as a 'prism' through which the success of change, need to change, and overall organizational efficacy was assessed. However, a need to 'meet people where they are at' was relevant throughout all themes and is clearly a factor in influencing *'change valence',* something which is more likely to lead to successful implementation (Weiner, 2009). In this study, it is notable that organizational factors which either supported or inhibited specific organizational change initiatives *or* helped to meet service user needs were discussed interchangeably, with no clear differentiation. This is broadly consistent with findings from quantitative studies, that many organizational characteristics, such as more openness to change, better team cohesion and good communication, which make a service good at adopting to change, can also relate to how effectively they can influence service user outcomes (Kelly et al., 2018; Kelly et al., 2017).

The provision of clinical supervision for example is something which can benefit organizational functioning across several domains. Supervision provides practical and emotional support for staff which in turn impacts on the retention of staff, their ability to adopt to change, and also helps them to form good therapeutic relationships with service users (Gonge & Buus, 2011; Wheeler & Richards, 2007). In practice, clinical supervision and other supports do not occur in a vacuum and their provision is likely to be indicative of a healthy organization (Pollock et al., 2017). Conversely, for participants in this study, where supervision was provided for some staff groups and not others, it negatively affected team cohesion and exacerbated a sense of 'them and us' between professional groups.

Many other factors identified here such as clinical audit, team meetings, good leadership, good communication with service users, clarity in job roles, adhering to guidelines and policy, and appropriate skill mix are all features of good clinical governance, which in if adopted correctly can act as a 'lever' in determining successful organizational change (Brault, Denis, & Sullivan, 2015). These are also aspects of a service which are indicative of a healthy organizational 'culture' (Jones, Jimmieson, & Griffiths, 2005). Staff attributes, team cohesion, leadership, communication with service users were some of the factors which support organizational efficacy. Other factors which are external to an organization, such as culture, societal values, policy and how services are planned were also considered to be important. This is consistent with other findings, which identify a broad range of factors which can influence organizational efficacy (Lewis et al., 2020; Louie et al., 2021). Overall, this supports an argument that changes to any aspect of a treatment service and supporting services needs to be considered systemically. In this respect, there is a clear need to 'join up the dots' which may be alternatively described as adopting a more systemic approach to the planning and delivery of services. Based on the findings in this study, this would involve much greater cohesion and co-operation between policy makers, service planners, staff and service users in order to ensure consistency and quality when delivering a range of services across geographical areas.

In relation to supporting specific change implementation or 'getting buy-in', demonstrating potential effectiveness through modelling or piloting and having clear benefits to service users was considered paramount in promoting the 'change message', developing a psychological discrepancy between current and desired practice amongst staff, and increasing belief in the ability to change (Stevens, 2013). A history of successful change implementation, stakeholder involvement, the provision of appropriate resources, leadership, and ensuring appropriate measurement and 'follow through' through clinical audit and clinical supervision were all identified as characteristics of successful change initiatives that result in multi-level 'buy-in'. These findings are all consistent with those emanating from studies in the field of implementation science (Dintrans, Bossert, Sherry, & Kruk, 2019; Weiner, 2009).

Recruitment and retention of staff was discussed as a factor which simultaneously inhibited the implementation of change and organizational ability to meet the needs of service users. In the context that providing OST services have significant economic benefits for wider society, the pay and conditions and career opportunities awarded to staff are likely to impact on this, and are worthy of further attention (Gossop, 2015; Kroezen et al., 2015). Maintaining good relationships with service users in order to obtain information about changing trends and emerging difficulties, is also likely to be of paramount importance as service user need was consistently identified as a driver of change. There is some indication of what organizational attributes facilitate better engagement with services users such as resources, organizational climate and staff attributes and these should be used to inform policy makers and planners when designing services (Greener et al., 2007).

The Irish context is also unique. There is a long history of the provision of healthcare in Ireland by the voluntary and private sector but most notably by the Catholic church, a body which has, historically at least, a significant impact on the shape of policy making and health and addiction services in Ireland

including an over-emphasis on the disease model of addiction (Barrington, 1987; Butler & Mayock, 2005). In this respect, study participants observed a 'paradigm shift' in services over the last decade or so, from abstinence focused ideology to what one interviewee termed 'compassionate pragmatism' or 'meeting people where they are at'. This shift was attributed to social and cultural factors which manifested in different ways in each service, through aspects such as new policies, physical aspects of buildings, changes in the skill mix of staff and changes to practice and leadership. Still, it appears that institutional stigma is still evident in some services through current practices in OST prescribing services and negative views of addiction (Mayock & Butler, 2021a; Woo et al., 2017). This 'status-quo' continues to create psychological discrepancy for some staff, who consider this both something that they would *like* to change, but paradoxically identify that this also presents a barrier *to* change (Weiner, 2009).

In Ireland OST services subscribe to high standards of care as outlined by 'Safer Better Healthcare' (Health Information and Quality Authority, 2012) but it is notable that unlike other jurisdictions such as the UK, there is no independent oversight of addiction treatment services in Ireland to ensure enforcement of these standards (Care Quality Commission, 2021). While aspects of good governance, such as clinical audit are evident and specific measures to standardise and improve the internal governance of OST services are explicit in Irish policy, this does not yet appear to have been fully accomplished (Department of Health, 2017; Doyle & Ivanovic, 2009). A partial but weakening explanation for this may have been Irelands 'lost decade' of economic recession from 2008.

Participants in this study identified that inconsistencies in adherence to prescribing guidelines between practitioners seems to be a particular challenge. However, consistency in service delivery, and appropriate risk management need to be appropriately supported requires adequate resources, training and greater attention to overall governance in services including the willingness or ability to support or sanction staff who underperform (Brown, Shankar, Cox, McLean, & Jory, 2013; Veenstra et

al., 2017). Similarly, inconsistencies in how services are delivered should be addressed through more effective leadership and organization which should also provide a bulwark against staff working in 'silos'.

Over ten years ago, national strategies were put in place to standardise services and to facilitate inter-agency working but these strategic recommendations have yet to be realised (Doyle & Ivanovic, 2009). Overall, more guidance relating to the composition of 'good' services is required and sufficient resources should be put in place to deliver them (Roche & Pidd, 2010). Implementing these and improving overall governance is likely to help to 'meet people where they are at' through 'joining up the dots' and thus increasing overall staff 'buy-in' in responding to immediate service user needs and adopting more significant changes into practice. In summary, based on the findings in this study, the following recommendations for policy and practice ought to be considered:

- The design and full implementation of policies which promote consistency and standardization across all addiction treatment services, this should include a focus on how to best recruit and retain staff
- External regulation/independent oversight is required to ensure accreditation of services, safe service provision, and consistent service delivery
- Inclusive clinical meetings with all disciplines present will support greater consistency in service delivery
- Sufficient resources should be made available for training, supervision and support across all staff groups and services
- Exemplars of change will help staff understand and adopt new models of service delivery, but the importance of leadership behaviours and other service attributes should also be considered

5. Conclusion

Organizations are complex ‘eco-systems’ and the specific characteristics of organizations are influenced by a plethora of overlapping and interdependent factors. The findings presented here have identified factors which are important and have implications for the planning and implementation of services, and policy development. While it is clear that these factors are interdependent, the nature of their relationship may be context dependent and whether or not there is a universal ‘hierarchy’ of factors is worthy of further exploration. Qualitative research yielded important insights into understanding the factors and circumstances that influence organizational functioning and successful change implementation in Irish community opiate prescribing services.

References

Alder P, & Alder PA. (2012). The epistomology of numbers. In Baker S & R. Edwards (Eds.), *How many qualitative interviews is enough?* (pp. 8-10). UK,: National Centre for Research Methods,.

Baker, S. E., Edwards, R., & Doidge, M. (2012). How many qualitative interviews is enough?: Expert voices and early career reflections on sampling and cases in qualitative research. In.

Barrington, R. (1987). *Health, Medicine and Politics in Ireland 1900-1970*. Dublin: IPA.

Bauer, M. S., Damschroder, L., Hagedorn, H., Smith, J., & Kilbourne, A. M. (2015). An introduction to implementation science for the non-specialist. *BMC psychology, 3*(1), 1-12.

Bengtsson, M. (2016). How to plan and perform a qualitative study using content analysis. *NursingPlus Open, 2*, 8-14.

Brault, I., Denis, J., & Sullivan, T. (2015). Using clinical governance levers to support change in a cancer care reform. *Journal of Health Organization and Management, 29*(4), 482-497.

Brown, S., Shankar, R., Cox, D., McLean, B. M., & Jory, C. (2013). Clinical governance: risk assessment in SUDEP. *Clinical Governance: An International Journal*.

Butler, S., & Mayock, S. (2005). 'An Irish Solution to an Irish Problem': Harm reduction and ambiguity in the drug policy of the Republic of Ireland. *International Journal of Drug Policy, 16*, 415-422.

Care Quality Commission. (2021). Service inspections: independent substance misuse services,. Retrieved from https://www.cqc.org.uk/guidance-providers/independent-healthcare/service-inspections-independent-substance-misuse-services

Colorafi, K. J., & Evans, B. (2016). Qualitative descriptive methods in health science research. *HERD: Health Environments Research & Design Journal, 9*(4), 16-25.

Crowther, D., & Green, M. (2004). *Organizational Theory*. London: Institute of Personnel Development.

Department of Health. (2017). *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025*. Dublin, Ireland: Department of Health, Ireland Retrieved from https://health.gov.ie/blog/publications/reducing-harm-supporting-recovery-2017-2025/

Dintrans, P. V., Bossert, T. J., Sherry, J., & Kruk, M. E. (2019). A synthesis of implementation science frameworks and application to global health gaps. *Global health research and policy, 4*(1), 1-11.

Dowling, M. (2006). Approaches to reflexivity in qualitative research. *Nurse researcher, 13*(3), 7-21.

Doyle, J., & Ivanovic, J. (2009). *National Drugs Rehabilitation Framework Document*. Dublin: National Drugs Rehabilitation Implementation Committee Retrieved from http://www.drugs.ie/NDRICdocs/ndrframework.pdf

Duke, K., & Thom, B. (2014). The role of evidence and the expert in contemporary processes of governance: The case of opioid substitution treatment policy in England. *International Journal of Drug Policy, 25*(5), 964-971.

Duriau, V. J., Reger, R. K., & Pfarrer, M. D. (2007). A content analysis of the content analysis literature in organization studies: Research themes, data sources, and methodological refinements. *Organizational research methods, 10*(1), 5-34.

Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). Qualitative content analysis: A focus on trustworthiness. *Sage Open, 4*(1), 1-10.

Erlingsson, C., & Brysiewicz, P. (2017). A hands-on guide to doing content analysis. *African Journal of Emergency Medicine, 7*(3), 93-99.

Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of convenience sampling and purposive sampling. *American journal of theoretical and applied statistics, 5*(1), 1-4.

Flick, U. (2018). *An introduction to qualitative research*: sage.

Foss, C., & Ellefsen, B. (2002). The value of combining qualitative and quantitative approaches in nursing research by means of method triangulation. *Journal of advanced nursing, 40*(2), 242-248.

Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *The qualitative report, 20*(9), 1408.

Gonge, H., & Buus, N. (2011). Model for investigating the benefits of clinical supervision in psychiatric nursing: a survey study. *International journal of mental health nursing, 20*(2), 102-111.

Gossop, M. (2015). The National Treatment Outcomes Research Study (NTORS) and its influence on addiction treatment policy in the United Kingdom. *Addiction, 110*(S2), 50-53.

Graneheim, U. H., Lindgren, B.-M., & Lundman, B. (2017). Methodological challenges in qualitative content analysis: A discussion paper. *Nurse education today, 56*, 29-34.

Greener, J. M., Joe, G. W., Simpson, D. D., Rowan-Szal, G. A., & Lehman, W. E. (2007). Influence of organizational functioning on client engagement in treatment. *Journal of substance abuse treatment, 33*(2), 139-147. Retrieved from http://ac.els-cdn.com/S0740547207000256/1-s2.0-S0740547207000256-main.pdf?_tid=98d2c6bc-6051-11e5-b152-00000aacb360&acdnat=1442834107_62c302a31f4e33ebafa1cd17431655a3

Health Information and Quality Authority. (2012). *General Guidance on the National Standards for Safer Better Healthcare,*. Dublin, Retrieved from https://www.hiqa.ie/reports-and-publications/guides/general-guidance-national-standards-safer-better-healthcare

Holt, D. T., & Vardaman, J. M. (2013). Toward a comprehensive understanding of readiness for change: The case for an expanded conceptualization. *Journal of Change Management, 13*(1), 9-18. doi:10.1080/14697017.2013.768426

Jones, R., Jimmieson, N., & Griffiths, A. (2005). The impact of Organizational Culture and Reshaping Capabilities on Change Implementation Success: The Mediating Role of Readiness to Change. *Journal of Change Management,, 42*(2), 361-386.

Jootun, D., McGhee, G., & Marland, G. R. (2009). Reflexivity: promoting rigour in qualitative research. *Nursing Standard, 23*(23), 42-46.

Kallio, H., Pietilä, A. M., Johnson, M., & Kangasniemi, M. (2016). Systematic methodological review: developing a framework for a qualitative semi-structured interview guide. *Journal of advanced nursing, 72*(12), 2954-2965.

Kelly, P., Hegarty, J., Barry, J., Dyer, K., & Horgan, A. (2018). The relationship between staff perceptions of organizational readiness to change and client outcomes in substance misuse treatment programmes: A systematic review. *Journal of Substance Use, 23*(3), 223-239

doi:10.1080/14659891.2017.1394385

Kelly, P., Hegarty, J., Barry, J., Dyer, K. R., & Horgan, A. (2017). A systematic review of the relationship between staff perceptions of organizational readiness to change and the process of innovation adoption in substance misuse treatment programs. *Journal of substance abuse treatment*.

Kroezen, M., Dussault, G., Craveiro, I., Dieleman, M., Jansen, C., Buchan, J., . . . Sermeus, W. (2015). Recruitment and retention of health professionals across Europe: a literature review and multiple case study research. *Health policy, 119*(12), 1517-1528.

Landrum, B., Knight, D. K., & Flynn, P. M. (2012). The impact of organizational stress and burnout on client engagement. *Journal of substance abuse treatment, 42*(2), 222-230. doi:http://dx.doi.org/10.1016/j.jsat.2011.10.011

Lehman, W. E., Becan, J. E., Joe, G. W., Knight, D. K., & Flynn, P. M. (2012). Resources and training in outpatient substance abuse treatment facilities. *Journal of substance abuse treatment, 42*(2), 169-178. doi:10.1016/j.jsat.2011.10.018

Lewin, K. (1958). *Field Theory in Social Science*. New York: Harper and Row.

Lewis, C. C., Boyd, M. R., Walsh-Bailey, C., Lyon, A. R., Beidas, R., Mittman, B., . . . Chambers, D. A. (2020). A systematic review of empirical studies examining mechanisms of implementation in health. *Implementation Science, 15*, 1-25.

Louie, E., Barrett, E. L., Baillie, A., Haber, P., & Morley, K. C. (2021). A systematic review of evidence-based practice implementation in drug and alcohol settings: applying the consolidated framework for implementation research framework. *Implementation Science, 16*(1), 1-29.

Mayock, P., & Butler, S. (2021a). "I'm always hiding and ducking and diving": the stigma of growing older on methadone. *Drugs: Education, prevention and policy*, 1-11.

Mayock, P., & Butler, S. (2021b). Pathways to 'recovery'and social reintegration: The experiences of long-term clients of methadone maintenance treatment in an Irish drug treatment setting. *International Journal of Drug Policy, 90*, 103092.

Mitchell, G. (2015). Use of interviews in nursing research. *Nursing Standard (2014+), 29*(43), 44.

Neergaard, M. A., Olesen, F., Andersen, R. S., & Sondergaard, J. (2009). Qualitative description–the poor cousin of health research? *BMC medical research methodology, 9*(1), 52.

Orton, J. D., & Weick, K. E. (1990). Loosely Coupled Systems: A Reconceptualization. *Academy of Management. The Academy of Management Review, 15*(2), 203. Retrieved from http://search.proquest.com/docview/210958966?accountid=14504

http://godot.lib.sfu.ca/GODOT/hold_tab.cgi?url_ver=Z39.88-2004&rft_val_fmt=info:ofi/fmt:kev:mtx:journal&genre=article&sid=ProQ:ProQ:abiglobal&atitle=Loosely+Coupled+Systems:+A+Reconceptualization&title=Academy+of+Management.+The+Academy+of+Management+Review&issn=03637425&date=1990-04-01&volume=15&issue=2&spage=203&au=Orton,+J+Douglas

Weick,+Karl+E&isbn=&jtitle=Academy+of+Management.+The+Academy+of+Management+Review&btitle=&rft_id=info:eric/&rft_id=info:doi/

Pollock, A., Campbell, P., Deery, R., Fleming, M., Rankin, J., Sloan, G., & Cheyne, H. (2017). A systematic review of evidence relating to clinical supervision for nurses, midwives and allied health professionals. *Journal of advanced nursing, 73*(8), 1825-1837.

Porras, J., & Robertson, P. (1992). Organizational Development: Theory Practice and Research. In M. Dunnette & L. Hough (Eds.), *Handbook of industrial and organizational psychology* (pp. 719-822). Palo Alto, CA.: Consulting Psychologists Press.

Roche, A., & Pidd, K. (2010). *Alcohol & Other Drugs Workforce Development Issues and Imperatives: Setting the Scene*. Retrieved from Adelaide,:

Sandelowski, M. (2000). Focus on research methods-whatever happened to qualitative description? *Research in nursing and health, 23*(4), 334-340.

Silverman, D. (2013). *Doing qualitative research: A practical handbook*: SAGE Publications Limited.

Simpson, D., & Dansereau, D. (2007). Assessing organizational functioning as a step toward innovation. *Sci Pract Perspect, 3*(2), 20-28. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2851070/pdf/spp-03-2-20.pdf

Skinner, N., & Roche, A. M. (2021). 'Very demanding. Extremely rewarding': Exploring the co-occurrence of burnout and engagement in alcohol and other drug workers. *Drug and alcohol review*.

Stevens, G. (2013). Toward a Process-Based Approach of Conceptualizing Change Readiness. *The Journal of applied behavioural science, 49*(3), 333-360.

Thomas, E., & Magilvy, J. K. (2011). Qualitative rigor or research validity in qualitative research. *Journal for specialists in pediatric nursing, 16*(2), 151-155.

Van de Ven, K., Ritter, A., & Roche, A. (2020). Alcohol and other drug (AOD) staffing and their workplace: Examining the relationship between clinician and organizational workforce characteristics and treatment outcomes in the AOD field. *Drugs: Education, prevention and policy, 27*(1), 1-14.

Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period. *BMC medical research methodology, 18*(1), 1-18.

Veenstra, G. L., Ahaus, K., Welker, G. A., Heineman, E., van der Laan, M. J., & Muntinghe, F. L. (2017). Rethinking clinical governance: healthcare professionals' views: a Delphi study. *BMJ open, 7*(1).

Von Bertalanffy, L. (2013). *General System Theory; foundations, development, applications*. New York: George Braziller.

Watson, R., McKenna, H., Cowman, S., & Keady, J. (2008). *Nursing Research: Designs and Methods E-Book*: Elsevier Health Sciences.

Weiner, B. (2009). A theory of organizational readiness to change. *Implementation Science,, 4*(67), 1-9.

Wheeler, S., & Richards, K. (2007). The impact of clinical supervision on counsellors and therapists, their practice and their clients. A systematic review of the literature. *Counselling and Psychotherapy Research, 7*(1), 54-65.

Woo, J., Bhalerao, A., Bawor, M., Bhatt, M., Dennis, B., Mouravska, N., . . . Samaan, Z. (2017). "Don't judge a book by its cover": a qualitative study of methadone patients' experiences of stigma. *Substance abuse: research and treatment, 11*, 1178221816685087.

Yates, J., & Leggett, T. (2016). Qualitative Research: An Introduction. *Radiologic Technology, 88*(2), 225-231.

Appendix 1. Interview schedule

Indicative interview schedule

1. What is your overall view of this service?
2. What do you think works well here?
3. What aspects of this organization could be improved?
4. Can you describe how this service helps service users?
5. From the service user's perspective, what could be improved at this service
6. How would you describe this services ability to adopt to change?
7. Please think about an organizational level change that was required in the last year;

e.g.: implementing training, adopting new practices or re-structuring.

   a) What do you think helped to facilitate this change?
   b) What do you think made this change difficult?

8. How do you think this treatment service can be improved?

Probing questions

Elaboration probe:

- Why exactly do you feel that way?
- Can you tell me more about…….
- Why is that important to you?

Detail orientated probe:

- When did that happen?
- Who else was involved?

Clarification Probe:

- You said that……. what do you mean by that?
- What impact do you think……..has on……..?

Silent Probe:

- Remain silent and wait for the participant to continue, perhaps nodding

Echo probe:

- use a simple reflection "you said that….." and ask "what happened next?"

Uh-huh probe: