Guide to the Standards of Proficiency for Social Care Workers

Domain 2

written by social care workers
for social care workers

Edited by Dr Denise Lyons and Dr Teresa Brown

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Although comprising individually written chapters, this e-book is a team effort creating a collective voice of social care practice. We are eternally grateful to the social care workers, in different stages of their writing and practice journeys, who sacrificed their limited free time during a pandemic, when they were frontline workers, juggling work, family life and COVID-19, to share their vast knowledge and practice expertise.

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- The Irish Association of Social Care Managers IASCM.

This e-book is also the product of an amazing partnership that began as a co-editing relationship and evolved into friendship. This book became our focus, a welcome distraction from the loss of our beloved family members in 2020, Teresa's daughter Hollie, aged 9, and my nephew Adam, aged 10. This book is dedicated to them both.

Hollie Brown Quail (March 2011 – May 2020)

Adam Lyons (February 2010 – June 2020)

Foreword

One of the most beautiful gifts in the world is the gift of encouragement. When someone encourages you, that person helps you over a threshold you might otherwise never have crossed on your own **(John O' Donohoe 1956-2008).**

We were very privileged to receive many gifts of encouragement for this project and we are delighted to include their voices as the foreword to this e-book.

Bernard Gloster (Chief Executive Officer TUSLA Ireland's Child & Family Agency, previously a social care worker and health services manager).

In late 2020 I had the pleasure of writing the foreword for a special edition of the Irish Journal of Applied Social Studies (IJASS) all of which focused on the competencies and development of the social care profession. In that journal, I had the pleasure of reflecting on a book preview as follows; "If you want to engage more on the 80 proficiencies, then the book preview by Denise Lyons and Teresa Brown is a snapshot of what is up ahead. This is an e-book with a chapter on each proficiency (that's a lot of reading), but it has all the hallmarks of being compelling because of the style of capturing the voice of social care workers with their understanding and experience of the proficiencies now set out to be achieved. That e-book might well be the basis within which the proficiencies, when they are reviewed, and no doubt they will be in the future, will be considered against that lived experience of the worker. The worker has so much to achieve in this new set of proficiencies…" I am delighted now to welcome that same e-book available for all to consider and reflect on. The format and style approach is particularly attractive as each domain has its own book within a book and that certainly means that social care workers and students can go to and indeed go back to specific parts and reflections. Written by social care workers, it is for social care workers and educators a unique opportunity. With 75 contributors, the base of experience and reflection is wide and rich. Enjoy Reading.

Mark Smith (Professor of Social Work University of Dundee Scotland, esteemed author, academic, and keynote speaker).

I am delighted to have been asked to provide this brief endorsement for this project and the five e-books that constitute it. I know both Denise and Teresa having served as external examiner for both their doctoral viva voces and it is great to see them bring their manifest commitment to and wide knowledge of social care to this project. The results of their labours are both comprehensive and impressive. They have taken the five CORU generic domains of practice and their associated proficiencies and have prevailed upon a host of experienced professionals to customise these for social care in a series of freely available e-books. It is a vital task the editors have taken on. Practice standards are of little use if they exist only in some codified and abstracted form. They only achieve any utility if they are grounded and contextualised in the messiness and ambiguity of social care practice. And this can only be done by those who have encountered and negotiated this complexity in their everyday practice. So, these volumes are, avowedly, written by social care workers for social care workers – each proficiency is explored and considered though a social care lens anchored in practice. Being anchored in practice, the books provide a rich and credible resource for practice educators in their work with students, but they will also generate discussion and reflection in staff teams. What struck me in perusing the list of contributors is just how broad a base social care is developing in Ireland – it is a profession coming of age. There are eighty chapters between the volumes and while there is rightly some overlap, most are written by different authors. This exercise will itself enhance the status, confidence and identity of the profession. Each of the contributors, but most especially Denise and Teresa, have given the profession a gift that comes from within the profession itself and is all the more valuable for these origins.

Pat Brennan (Director of first social care programme (childcare) in Kilkenny 1971-1981, child care consultant, author).

There is no way I could do justice to this 2021 publication 'Guide to the Standards of Proficiency for Social Care Workers'. It contains eighty contributions from highly qualified and experienced authors. The range of knowledge, research, qualifications, experience and education/training is quite stunning. This guide is a huge compendium, starting with the key term: Social care is … a profession that requires an in-depth understanding of and interest in people. Practice is centred within the relationship between you and another person. Social care work places an onus on the worker to constantly reflect on her/his attitudes, physical and mental health and ongoing ability to focus on and be present with the service user(s). The work is emotionally and physically challenging because you use your self as the 'tool' (Lyons 2013). Every possible aspect of the work of social care is essayed with added examples, key terms, cases, tasks, tips for educators, references and biographies. All the time rooted in best practice, in accordance with legal and statutory requirements, underpinned by social justice and human rights. The emphasis is on human relationships with clear and principled explorations of what can be a fraught area of endeavour and task. In the long run, education and training are central, enabling students to move through knowledge to wisdom so that they do not work 'to the book', but to the reality and the needs of their clients. The main tool being the 'Self. It is an astonishing, comprehensive articulation of the work. It will surely remain the fundamental text with regard to social care for many years to come. This then should give all those in anyway involved in social care great confidence in themselves and in their profession. It must also give substantial standing within the whole welter of professions concerned and involved with the citizens and agencies of this State. An outstanding achievement, heartiest congratulations to all concerned (Pat Brennan, Kilkenny 2021).

Noel Howard (First Social Care Ireland Media Spokesperson, Editor of the CURUM, Leader in the professionalisation of social care work, to name a few of his many roles within social care over his long career).

The editors of this work took on a gargantuan task. Not only did they succeed in that task, but the results are foundational for those who are and will become part of a profession faced with another gargantuan task – making a difference in the lives of those with whom they are privileged to work. Social care workers simply have their own personalities, forged by their past and influenced by their experiences and training, to bring with them to do what they do each day. Denise and Teresa have delivered a rich, comprehensive touchstone, covering the myriad aspects of what that is all about. Moreover, it is written by the real experts, who know in their hearts and souls the loneliness of despair, the stultifying jargon of bureaucracy, the humbling lived experience of misery and failure as well as the uplifting light of the small steps of success. The editors and contributors are to be congratulated and thank you for the touching dedication.

List of Contributors

Dr Denise Lyons is a social care worker who lecturers on both Social Care and Creative Skills modules in the Institute of Technology Carlow. She is also a qualified art therapist. Denise served as secretary for Irish Association of Social Care Educators (IASCE) for five years, and was one of the founding members of Social Care Ireland Executive, serving as president from 2012 until 2014. Denise's publications include Creative Studies for the Caring Professions (2010) and Social Care: Learning from Practice (2014), which she co-edited with Noel Howard. Denise's PhD, which she completed in 2018, explored the experiences of social care workers in different settings.

Dr Teresa Brown is a social care worker currently lecturing on Social Care degree and masters' programmes in the Technological University of the Shannon: Midlands Midwest TUS. Teresa has extensive experience as a social care worker in Northern Ireland, Ireland and Romania. She has practised in the areas of residential care, secure care and child protection/family support. Teresa is currently a board member of Social Care Ireland and an active member of the Irish Association of Social Care Educators (IASCE). Her PhD, completed in 2016, focused on social care workers' experiences of relationship-based practice.

Vicki Anderson is a social care worker currently lecturing in the Institute of Technology Carlow. Prior to lecturing, Vicki had practice experience in children's residential care services and in disability services. She was Vice Chair of the Irish Association of Social Care Educators (IASCE) from 2011 to 2013, during which time she was a board member of Social Care Ireland.

Deirdre Berry qualified as a social care worker with a BA (Hons) in 2006. She has practice experience in mainstream residential and after-care services and has worked in the area of domestic, sexual and gender-based violence for over thirteen years. Deirdre has a keen interest in human rights and gender-based violence. She has vast experience working with the family court system, child protection, mental health, homelessness, family support and addiction services. She holds a master's in Advanced Social Care from Athlone Institute of Technology and a special certificate award in Team Leadership and Supervisory Management.

Bernie Breen has over twenty years' experience working in the field of social care. She holds a BA (Hons) in Applied Social Care and an MA in Social Care Leadership and Management. Bernie is one of six professionally accredited therapeutic crisis intervention trainers in Ireland and her MA research focused on 'Social care managers' perspectives on factors which support or impede the implementation of therapeutic crisis intervention (TCI) systems in children's residential care services in Ireland'. Bernie is Director of Services with TerraGlen Residential Care Services, which provides mainstream and disability residential and respite services.

Marian Connell is a lecturer in Applied Social Care in Technological University Dublin, Tallaght Campus. She lectures across the programme in Applied Social Care, Creative Group Work and Facilitation Skills, and Facilitating Arts in Social Care. Prior to becoming a lecturer, she worked in a variety of residential care settings, in family support as a social care worker and in management. She has fifteen years' experience as a child psychotherapist and 28 years' postgraduate training as a social care worker. She has a degree in Social Care, postgraduate diplomas in Child Art Psychotherapy and Practice Based Play Therapy, and an MSc in Child Art Psychotherapy.

Natasha Davis-Dolan is a social care worker currently working in partnership with children, young people and families who are at risk. Natasha holds an ordinary degree in Social Studies in Social Care and is currently undertaking her honours degree in Athlone Institute of Technology. Natasha's focused interest is in the area of care and aftercare, particularly the effect on children and young people who enter the care system of separation and loss, and attachment. Natasha is a qualified financial adviser, having spent sixteen years working for a large Irish financial provider before making the decision to return to education in 2016.

Maeve Dempsey is a social care lecturer with Limerick Institute of Technology and has over eight years of teaching experience. She has previously worked in mainstream residential care, youth and community work, and the disability sector, and continues to work as both a facilitator and consultant for supervision in social care and developing effective communities of practice within organisations. Maeve holds a BA (Hons) in Applied Social Studies (Professional Social Care), an MSc in Criminology and Criminal Justice from University College Dublin and is currently undertaking a diploma in Clinical Supervision.

Diane Devine is a social care worker for over seventeen years, and her experience includes management in day services. Diane specialised in the education and training of adults with additional needs in day services; earlier in her career she worked with children in the specialised care sector. Diane is a lecturer in the Department of Lifelong Learning, Institute of Technology Carlow. She lectures across Social Care and Childcare programmes. Diane also holds a B.A Degree in Arts – Community Studies, an MA in Child, Youth and Family Studies,, a Diploma in Local and Community Studies from National University of Ireland Maynooth, a certificate in Supervision, Theory and Practice, and qualifications as an adult literacy tutor and a Teaching English as a Foreign Language (TEFL) tutor.

Paul Hogan is a lecturer in social care in Athlone Institute of Technology. As well as his social care degree, he holds an MA in Child and Youth Studies and is currently undertaking postgraduate research on family homelessness. Paul co-ordinates practice placements for students. He was involved in politics for fifteen years and has particular practice interest in homelessness, youth, direct provision and community development.

Dr Ailish Jameson, a social care lecturer in Technological University Dublin, is also a relief social care worker in homeless services. Her PhD, which she completed in 2019, explored emotional intelligence (EI), graduates and employability. Part of this PhD was the design and delivery of an EI coaching programme for final year students, tailored to the specified needs of employers. Ailish completed the Applied Social Studies in Social Care degree in 2010. She has a major interest in wellbeing, in particular mindfulness interventions to address stress and burnout, and is a trained mindfulness teacher. She facilitates mindfulness sessions on a voluntary basis in educational settings, to individuals deemed at risk and to members of the public.

Gillian Larkin is a lecturer in Applied Social Care at Technological University Dublin, Tallaght Campus. She lectures across the programme in Professional Practice, Management and Supervision in Social Care, Leadership and Organisational Change in Social Care and Strategy and Governance in Social Care. Prior to becoming a lecturer, she worked in family support and residential care settings for fifteen years, and for the last ten years has worked on a voluntary basis coaching and mentoring people experiencing difficulties with addiction and mental health. She is currently completing a MA in Applied Psychology (Positive and Coaching Psychology).

Eleanor Lyons is currently working as a social care worker/deputy manager in a residential house for adults with intellectual disabilities. Eleanor graduated from the Institute of Technology (TU Dublin) Blanchardstown with a degree in Applied Social Studies in Social Care. Eleanor's family were foster parents for children in emergency care and she grew up with a keen interest in social care. She also worked with Dublin City Council on their student activity programme, which aimed to empower young people from the inner city.

Garreth McCarthy is a social care worker currently working in an addiction community service as part of a multidisciplinary team in Dublin's North Inner City region. Garreth previously worked in numerous residential homeless services including a family hub, supported temporary emergency accommodation and one night only emergency hostels for five years. Garreth completed his honours degree in Social Care at Technological University Dublin, graduating in 2020 and completed a master's degree in Social Science (Rights & Social Policy) at Maynooth University in 2021.

Des Mooney is a social care leader working with children in residential care in Dublin South. He also teaches and writes about the practice of social care. He holds a BA (Hons) in Social Care and an MA in Higher Education. His research interests include social care practice, therapeutic care and communities, supporting recovery from trauma and negative early life experiences, and lifelong learning. Des was a member of the Social Care Workers Registration Board from 2015 to 2021.

Evonne Mushonga is a social care worker who began her career with the Ana Liffey Drug Project (homelessness and addiction). She is currently working in the community with HIV Ireland as a support worker. After graduating in 2017, she has continued her studies in the area of counselling and psychotherapy. Evonne is currently serving as a board member with Rooted in Africa and Ireland (RIAINetwork), an initiative that aims to tackle and promote anti-racism in Irish society.

Shauna O'Regan is a social care worker currently working in day services for adults with intellectual disabilities. Shauna has also worked in adult residential care and residential services for children with autism. She graduated from Technological University Dublin, Blanchardstown Campus with a degree in Applied Social Studies in Social Care in 2019 and has been working in the disability sector since then. Shauna is currently completing a course in Positive Behavioural Support with the Open Training College.

Collie Patton has worked in social care for the past fifteen years, in both frontline and academic roles. His practical work has primarily been in residential and day programme development and delivery, with a special focus on therapeutic work in the outdoors for those living with an additional challenge. Collie currently works for Active Connections Inc and was instrumental in creating a therapeutic outdoor programme for children and adults with additional needs, which currently runs in seven counties in Ireland. He delivers Continuing Professional Development (CPD) programmes with CARA that focus on sports inclusion, and teaches on Dublin Business School's and Limerick Institute of Technology's Social Care degree programme. Collie holds a BSc (Hons) in Chemistry, graduate degrees in Applied Social Studies (Professional Social Care) and Business Administration, and an MSc in Behaviour Analysis.

Gráinne Powell, a graduate in Family Support/Social Care, has a range of expertise in the areas of community development, drug education and parenting. Gráinne has worked for many years as a health promotion officer with the Health Service Executive delivering health and wellbeing initiatives in line with national policy priorities. Prior to this she was a youth and community worker. Gráinne is a trained parenting practitioner and is currently undertaking research in this area.

Tanya Turley has worked with and continues to manage organisations involved in the social care arena such as crisis intervention services, child protection, residential care, youth services, community development, therapeutic and family resource work for the past twenty-three years. Tanya holds an MA in Therapeutic Childcare, a BA (Hons) in Applied Social Studies and Combined Management, an HDip (Hons) in Adult Education and Community Development, a Diploma in Psychology (NUI Maynooth) and a Teaching English as a Foreign Language (TEFL) qualification. Tanya has lectured in the Faculty of Lifelong Learning and full-time daytime courses across the Early Years Education and Social Care programmes in the Institute of Technology Carlow since 2005. Her ethos of work is a person-centred approach with areas of special interest that include trauma informed practice, adverse childhood experiences, polyvagal theory, resilience, and attachment.

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Introduction

Wednesday, 31 May 2017 was a landmark date. On that day CORU launched the Standards of Proficiency for Social Care Workers and started the clock ticking towards statutory registration. CORU was assigned the task, under the Health and Social Care Professionals Act 2005, of establishing the criteria for all twelve professions included in the legislation. CORU designed the standards of proficiency to include five domains, and the first four (professional autonomy and accountability; communication, collaborative practice and teamworking; safety and quality; and professional development) were deemed generic, forming the general guidelines for all twelve professions. Domain five, described as profession-specific (SCWRB 2017), was adjusted to suit each discipline.

This book is a professional response to the standards of proficiency, written entirely by social care workers for students, workers and educators. Here the voice of social care workers is at the centre of each standard of proficiency, providing a valid, meaningful and practice-rich discussion. The book has a single chapter on each of the eighty proficiencies. Each chapter represents the writer's understanding of the proficiency they have chosen and offers insights into the context in which they work, their professional relationships, and how these shape their professional identity as social care workers. A lot of practice is performed intuitively and draws on personal and professional knowledge and experience built up over a lifetime.

The standards of proficiency are portrayed as a threshold framework for creative and informed practice that views service users as central to social care work. Here the worlds of practice, policy, research and regulation are brought into much closer proximity, presented as an integrated practice-informed body of knowledge with the relationship at the core. The keywords and language of the proficiency are explored and considered though a social care lens anchored in practice. A unique section of each chapter is called 'Social Care is …', in which the author explains what social care practice means to them, based on their knowledge and experience. The aim here is to provide as many perspectives as possible on what this evolving profession means to social care workers. Reflections of practice are drawn upon from the 'coal-face' using fictional case studies to maximise students' engagement with the proficiency. The final section of each chapter contains 'Tips for Practice Educators' with a focus on how they might teach the proficiency as practice educators, using practical exercises, reflective questions, quotes and points to consider. The social care workers involved have given their time and expertise to help strengthen the profession and their contributions are a testament to their competence, generosity, passion and pride in social care work.

- Social care worker is a protected title, and the preferred professional title by authors in this publication. In some chapters, authors have used 'social care practitioner', and 'social care worker' interchangeably.
- The Case Studies included in this eBook are either completely fictional, or loosely based on real people. In all cases, names and identifying details have been changed.
- Remember all the links in the chapters and references list are live, so use them to find other relevant resources to support your practice and education.
- This book was written by 75 of us, for you, so enjoy.

Chapter 24 – Evonne Mushonga

Domain 2 Standard of Proficiency 1

Be able to communicate diagnosis/assessment and/or treatment/management options in a way that can be understood by the service user

KEY TERMS

Assessment
Diagnosis
Treatment options
Communication

Social care is … the ability to empower others to speak up for themselves and to make a difference in a person's life.

This proficiency can be specifically applied to various social care contexts. The importance of communicating treatment interventions in a way that can be understood by the service user is one of the central elements of social care practice. Social care workers provide a broad spectrum of care with diverse people in response to the political, economic and social demands occurring globally. The practice sphere of the social care worker has expanded greatly because the competencies and skills of social care professionals can be positively transferred into different areas of care and support, for example working with older people, domestic violence support, homeless services and addiction services. This chapter is based on my experience as a social care worker in one of these new practice settings, a service for people diagnosed with the human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). In order to help you, the reader, understand this proficiency, I decided to base the chapter around how this service communicates the diagnosis/assessment and/or treatment/management options available to people with HIV or AIDS. The case studies presented here are fictional but are used to demonstrate an effective and supportive way to communicate information on the diagnosis, assessment and treatment options for people receiving an HIV positive result (Jamison *et al.* 2006).

The organisation I work for operates under an ethos of equality and is committed to making a positive contribution towards a humane and just society (HIV Ireland 2015). This service strives to ensure that all staff, volunteers and service users are always treated with dignity and respect in an environment that promotes equal opportunity and prohibits discrimination. The main aim of the organisation is to raise awareness and provide training, support and advocacy; it also provides free community HIV and sexually transmitted infection (STI) testing, free counselling, a free resources service, as well as disseminating free condoms in the community. In this service, social care workers are referred to as support workers and the service users as clients.

Assessment

HIV is a virus that attacks the body's immune system. The immune system is made up of different cells that protect and defend our bodies from germs and infections. HIV attacks CD4 cells (known as T-cells) in the immune system. These cells are vital for keeping our immune system healthy and effective. Having HIV means that the body is less able to fend off infections (HIV Ireland 2015).

The assessment interview is the initial opportunity afforded to a social care worker to start building a working relationship with a client. Through the interview process the client's past experiences and coping strategies are discussed, along with their goals for treatment. At the same time, the client's strengths and unique needs are identified, which helps the service ascertain the best intervention strategy for them. The assessment is a long process that begins with the initial interaction with the client and continues throughout the duration of the intervention (HIV Ireland 2015). The assessment process establishes the social care worker as one part of the client's support system. Therefore, it is important for the worker to be patient and sensitive to the client's needs in order to gradually find out from the client how they can be of support. It is necessary to aid the client to build their own support network, in addition to the service, to have better and longer-lasting outcomes. As a worker, the support you provide is social, emotional and, most important, empathy.

The ability to display empathy is vital in validating the client's feelings. Empathy assists in the acceptance of the client's plight, and enables them to realise that they are being genuinely listened to. Empathy in practice means accepting and understanding the client's feelings, which may help you to become better equipped to facilitate the service user to help themselves. This requires learning and experience and can be achieved through practice (Gilbert *et al.* 2017). During the assessment phase it is vital not to be judgemental about the client's circumstances, but rather to adopt a neutral position. You can achieve this by keeping an open mind and by not imposing your own religious, political and personal views on the client. It is also important to read and learn the social care workers' code of ethics to guide one's judgement (SCWRB 2019).

The first case study illustrates the background information that is shared during the initial assessment process. This case study is fictional but is based on the type of assessment process people who have received a diagnosis of HIV/AIDS may experience.

Case Study 1

Assessment Stage

The fictional client is a male called John, and he is in his late 50s. John was once married, and has two children, who are in their 20s. John has been unemployed for more than more than five years. John stated that he lived a happy life before he lost his job. He worked as a security man for a long time and provided for his family well. The second tragedy he discussed was the breakdown of his family. This was precipitated by his heavy drinking tendencies that became worse after losing his job. During this time, his wife left him, taking the children with her, and John remained in the family home. In the beginning the children visited him regularly, but John was unable to keep up with the mortgage repayments and the family home was repossessed. John now lives rough on the streets. John stated that he comes from a strong family and his mother, three sisters and two brothers are all still alive. He described how his family looked up to him as a father figure after the death of his own father.

Since last year John has come out as gay to his family. He met a young man in a homeless shelter and they began dating. Although his family know he is gay, he has concerns about their acceptance of him as they hold strong Catholic beliefs. In the final part of the initial assessment, John discussed how he suspects he has contracted HIV. John does not know much about HIV and AIDS. He considers HIV a death sentence. He does not know about medications or if they will work very well if taken as prescribed. All this confusion is expressed during the assessment meeting, as it is not confirmed at this stage that he has contracted HIV.

Trust-building skills were employed during John's assessment phase. A strong therapeutic relationship with the client is developing, through helping him identify a support system, accurately assessing his needs, and empathising with his own unique situation in a non-judgemental and value-neutral way.

Because John felt safe, he opened up about his life and volunteered information to the support worker. He stated that he felt comfortable and looked forward to the next meeting. It is important to note that if the social care worker does not feel that John is able to process all this information, they can refer him to a counsellor to provide additional support at this time (Kabir 2017).

Diagnosis

Diagnosis can be referred to as the process of helping the client to make sense of their medical condition. It can also be part of the assessment process. In the case before us, the client is worried that he may have contracted HIV. As a result, there is a medical diagnostic process that needs to be performed. However, the diagnostic process must be supported with clear and accurate verbal communication, patience and empathy.

Case Study 2

Diagnostic Stage

Meetings continued regularly between John and me. After two months John could not be found. I suspected that it was a result of our last discussion, in which I suggested that there was a need for him to know his HIV status. At the time, he was not too keen to know. He gave me the impression that he did not want to know; however, John promised me that he was going to think about it. I was committed to help John and work at his pace, but I felt it was important to reach out to him.

A week elapsed without yielding any results. At the end of the second week, I came into contact with him. He was very surprised that I was looking for him, but he appreciated the care and concern. He stated that he did not come to our meetings because he still had not made up his mind whether to check his HIV status. I told him that he will never be forced to know his diagnosis. However, I explained the advantage of knowing early, especially if he was HIV positive. I discussed the benefits of early intervention. The following morning, I was surprised to receive a phone call from John. He told me that he wanted to meet me as soon as possible and we made an arrangement to meet the following day. He told me he was ready to know his HIV status. I further explained that diagnosis can happen in two ways: self-diagnosis by home testing with kits provided by HIV Ireland; or through hospitals and/or clinics. He suggested we go to hospital, and we did. The hospital staff were very respectful and provided a private room for the consultation. I continued to assure him that everything would be alright regardless of the outcome. He was shaky but still wanted to go through the process. His diagnosis was HIV positive, and I stayed with him to help him understand the information provided by the clinician.

When John found out his HIV status, he did not want to discuss anything further that day. He told me he would be in contact as soon as he was ready to talk. I respected his wishes, at the same time encouraging him to consider early intervention. He promised he would be in touch before long. After a few days John phoned again and said he was in a position to meet me. This time I decided to meet him in a hotel setting. I bought him lunch just to make him feel loved and cared for. It was important to show him I cared so much about him. After lunch we sat in the lounge, far from everyone else for privacy. John told me he had not been in a hotel for some time and expressed his gratitude to be there. Before long, we got into a serious conversation. He told me he did not understand how I could say things were going to be okay when he was HIV positive. That question gave me a chance to explain to him all the treatment that is available for people living with HIV. This was the next step of my journey with him after diagnosis, to explain the following points so that he could ask questions and take his time to digest the information.

- HIV is no longer a potentially terminal illness; it is a chronic illness and people can live long and healthy lives if they adhere to their HIV medication, attend hospital appointments, and take care of their general health.
- If someone is taking their HIV medication and has 'undetectable' HIV viral load (as will be determined by their physician), HIV cannot be passed on to their sexual partner(s).
- Even women who are living with HIV and who are adhering to their HIV medications can give birth to HIV negative babies (WHO 2007).

- A person living with HIV (PLHIV) who has a good immune system may not need to take medication but will have regular check-ups.
- A PLHIV will regularly attend hospital every 4-6 months to have their viral load and CD4 count checked.
- Ongoing counselling and support are crucial at this stage.

Towards the end of the meeting John burst into tears, telling me that he had wasted his life. He was in despair and did not know how he could get back to his old self again. I assured him I would be there for him and would do my best to help him start a new life. At the end of the meeting, I was happy that John had expressed the desire to turn his life around. The next day I made an appointment for him at the hospital, and he started treatment.

The role of the support worker is to support the client with their diagnosis, provide accurate information and guide them in their HIV journey. Also vital to a person living with HIV is peer support; Positive Now is a national peer support group that runs support/social groups, workshops, forums and conferences for people living with HIV (HIV Ireland 2015). The newly diagnosed can benefit from peer role models who can identify with the shock of a positive diagnosis while also explaining that HIV is no longer a terminal illness. Peers can also help orientate and support people living with HIV around the important issues of medication compliance and disclosure (Rouleau *et al.* 2019). As HIV-related stigma is still prominent in society and is equated with sexual activity and/or drug use, it is important for the social care worker to be open-minded and non-judgemental. Social care workers need to educate themselves on how HIV is and is not transmitted. It can only be passed on through unprotected sex, from mother to unborn child (if the mother is *not* on HIV medication), and through infected blood products (which, in Ireland, is extremely unlikely) (WHO 2016).

Someone living with HIV might not return or engage further with the service if he or she feels judged, or if the social care worker, fearing possible infection, treats the person living with HIV differently from others. Such actions and attitudes will further compound the vulnerability of the client. Often people living with HIV feel a lack of control over their lives, particularly around the issue of choosing to disclose or not to disclose their HIV positive status. In respecting the service user's wishes, and in considering their feelings, service providers can help them regain a sense of control over their circumstances. Additionally, social care workers have the responsibility to educate themselves about the rights of service users who are living with HIV and to ensure that service users know and understand these rights. This can help to empower service users to ask questions, especially about the decisions being made on their behalf.

Treatment Options

HIV treatment is also known as antiretroviral therapy (ART), or highly active antiretroviral therapy (HAART) (WHO 2016). Treatment with anti-HIV drugs is often called combination therapy because people usually take more than one drug, usually three, at the same time – often combined into one tablet. Current HIV treatment is not a cure for HIV (WHO 2016). It can keep HIV under control, but it does not eliminate HIV. HIV treatment works by stopping the virus from reproducing in your body. It can reduce the amount of the virus (your viral load) to very low (undetectable) levels (Rouleau 2019). If you are taking HIV treatment regularly and have an undetectable viral load, this lets your immune system stay strong, and, if the virus has damaged it, allows it to recover. Since antiretroviral therapy first became available in the mid 1990s, enormous progress has been made in the treatment of people living with HIV such that, for many, life expectancy is similar to that of the general population (WHO 2016). If you are taking HIV treatment correctly, and achieve and maintain an undetectable

viral load, there is effectively no risk of passing HIV on to others. HIV treatment is beneficial from an individual perspective, in that it keeps your immune system strong, prevents illness and improves your life expectancy. HIV treatment is also beneficial from a population perspective in that it prevents HIV being passed on to others. This is known as treatment as prevention (TasP) (WHO 2016).

Communication

Case Study 3

Treatment and Living with HIV

It is six months now since John started medication. He has been very consistent in taking his medication. As a result, the doctor has told him that the HIV is no longer detectable in his body. John is keen to turn his life around. He has paid frequent visits to his brothers and sisters. He makes sure he is sober and clean during the visits. He wants to win their trust again. His siblings are extremely happy about him. One of the brothers has been arranging meetings between him and the children.

However, John is faced with the challenge of communicating with friends and family about the HIV diagnosis. He wants to be honest, but at the same time he is not sure about his loved ones' reaction. Following discussions with the family, a meeting was arranged at which John was going to let his family know what had transpired in his life, including the HIV status and the gay relationship. I helped him to prepare what he was going to say to his family. At first, they were horrified about both issues. I gave them some comprehensive education on HIV and the fact that the virus is now not detectable. At that point the family became relieved and had the opportunity to ask questions in a safe and non-judgemental environment. At the end of the meeting, we discussed the importance of their family as John's support network in living with HIV.

Communication is key when dealing with service users who are HIV positive. The newly diagnosed are often given a lot of information by practitioners and is important to determine whether the service user has understood the information relayed by the medical practitioner (HIV Ireland 2015). While social care workers are not medically trained, there are World Health Organisation-endorsed key messages which social care workers should ensure people living with HIV understand (WHO 2016).

This is the most important first step in the process of communicating important information to the service user. The following are the key steps to consider:

- Establish a relationship with the service user. This is paramount because you need to make sure they are comfortable telling you everything that is going on, which will be better for them and their health.
- Communicate with the service user. Explain the issues to them in a language that they understand and check with them whether they understood what the consultant said.
- Meet the service user where they are at and listen to them in a non-judgemental way.
- Assure the service user that HIV is a chronic illness, not a terminal illness, and the treatment will enable them to live a long life.
- Develop trust with the service user by having open and honest communication.

For many people living with HIV, counselling and support is a vital service for them and their significant others. Often service users who are newly diagnosed request support around disclosing their HIV positive status to family, friends and, particularly, partners. Communication is key, and part of the role of the social care worker is to support the service user to communicate information on their diagnosis to their friends and family (HIV Ireland 2015). They may need to develop coping mechanisms in relation to their diagnosis and living with a chronic, and stigmatised, illness. Those living with HIV for many years can also benefit from counselling as HIV-related issues arise in their lives. This is another example of the importance of establishing a relationship based on trust and respect, achieved through checking back in with the service user on how they are living and coping with this diagnosis (HIV Ireland 2015).

The story of John above is a good example of how much a trustworthy relationship between client and support worker can achieve. In the case study the social care worker did not relent on visitations. She realised the client wanted to turn his life around and she helped. Similarly, when the client wanted to communicate his HIV story, the social care worker was present, and she helped the client to reach out to his family for support.

Conclusion

Through support, advocacy and training, social care workers can help to improve the lives of PLHIV and those affected by HIV. The agency I work for values the rights of service users and seeks to ensure that service users understand and exercise these rights and that they do not experience HIV-related stigma in society by promoting HIV and STI testing, educating communities, and empowering people living with HIV to self-advocate. Living with a stigmatised illness such as HIV can be very difficult for those affected by the illness and they may feel hesitant working with service providers. However, by ensuring there is good communication from the beginning of engagement, by remaining compassionate and non-judgemental, the service provider and the social care workers can optimise service user engagement and be able to communicate diagnosis/assessment and/or treatment/management options in a way that will be understood by the service user.

Tips for Practice Educators

Trust-Building Skills

- The ability to display empathy is vital in validating the client's feelings.
- During the assessment phase, it is vital not to be judgemental of the client's circumstances, but be neutral at all times.
- Remember that the assessment is to help the social care worker develop the best intervention strategy to meet the client's unique needs.
- Social care workers need to be sensitive and supportive of their client, and this comes in the form of social support, emotional support and empathy.
- It is imperative not to be judgemental of your client's circumstance but be able to keep an open mind without imposing your own religious, political and personal views on your client.
- Identify factors that can diminish a client's acceptance of a new person in their life. Deal with them, then you will be able to support the client.

Communication Tips

- Listen more than you speak.
- Understand the client first before making a comment and never interrupt.
- Understand the needs, wishes and values of the client.
- Begin with empathy.
- Take responsibility for your own feelings.
- Make requests that are practical, specific and positive.
- Use accurate, neutral descriptions.
- Be willing to hear 'No'.

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Chapter 25 – Shauna O'Regan

Domain 2 Standard of Proficiency 2

Be able to modify and adapt communication methods and styles, including verbal, non-verbal methods to suit the individual service users considering issues of language, culture, beliefs and health and/or social care needs.

KEY TERMS

Language
Culture
Beliefs
Health and social care needs

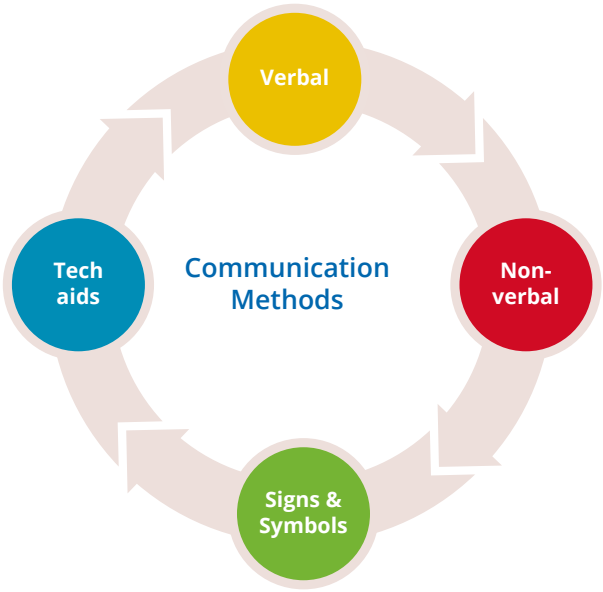
Social Care is … using skills you have learned, your professional development to influence the lives of people you work with. Through a person-centred approach to enable people to live a full life, unhindered by societal barriers. It is the proud feeling when witnessing someone accomplish a new skill that will forever benefit them in their day to day life with tools you have helped them to master.

TASK 1

Can you remember a time when you, or a service user, did not receive a service or support as a result of challenges in communication methods or styles?

Communication Methods and Styles

When many people think of communication and communicating with others, they think of the most common form of communicating, speaking. People forget that there are many more forms of communicating through language than just spoken communication. Language can be spoken or written but can also be signed. Sign language is a skill mostly taught to people who have impaired hearing and those in their immediate circle, i.e. their family. As a social care worker who may be working with service users with hearing impairments it would be useful to learn basic signs that would allow you to open up a line of communication with the service user. This is just one simple way of how you can adapt your communication style within the social care environment. Although this is a great way to open up lines of communication with service users, it is important to further develop your professional skills by going to courses and seeking training in this style of communication. The many different areas of social care will affect how as a practitioner you will adapt and change your method of communicating; for example, an office-based position will involve using written and technological methods of communicating. It will also change depending on the demographic you are communicating with, i.e. clinicians, floor staff, families of the service users or the service users themselves. Floor staff will be in direct contact with the service users, which will entail face-to-face communication. Below I will detail the different methods and styles of communication that can be used in the social care setting. I will then go into detail about the key terms highlighted above; language, culture, beliefs, and health and social care needs.

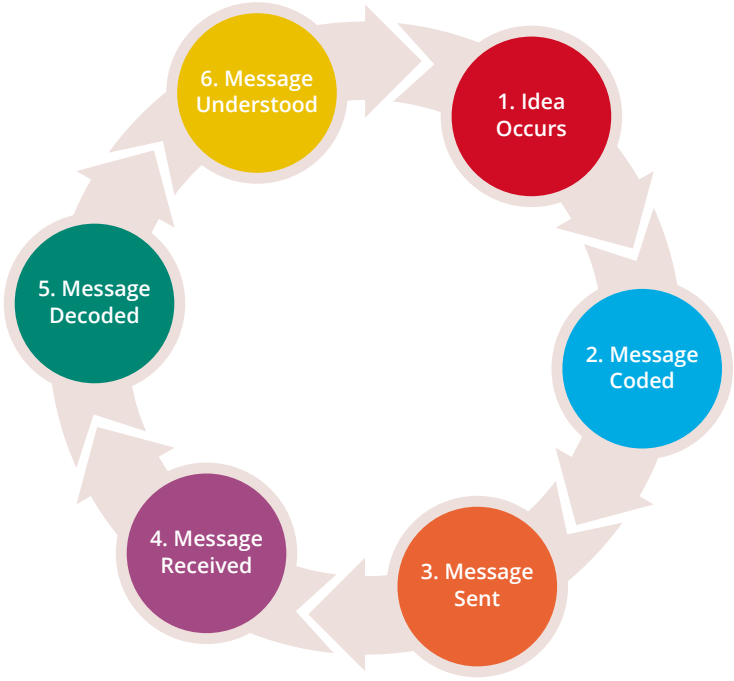


TASK 2

Question: Can you identify a time in your personal life when you adapted your method of communication?

Answer: Every day. We change how we communicate whenever we speak or text someone of a different age or nationality, e.g. we speak to our grandparents differently from how we speak to our friends and we speak to lecturers in college differently from how we speak to fellow students.

Verbal Communication



Service users who communicate verbally to staff and to others will do so in their own way and to the best of their ability. Some service users may use their own way of speaking. Verbal communication involves more than just speaking to someone and them responding. The communication cycle demonstrates this (see diagram). Effective verbal communication involves six steps; however, when working within a social care setting it is important to recognise that this process may take longer for some people that for others. If you are working in the disability sector, it is evident that the decoding stage may take longer to process. Thus, it is vital as a social care worker to allow the service user time to decode the message before they respond. In practice you must not rush service users or overload them with more information than necessary, as this may impact on their ability to decode and understand the verbal cues. It is important to give service users time to complete the communication cycle before they are expected to respond.

Non-verbal Communication

Non-verbal communication includes a multitude of different ways in which someone communicates, for example body language, eye contact and gestures. It is necessary for a social care worker to familiarise themselves with service users' non-verbal communication methods in order to maintain a pathway to communication. An example of this would be that if you are to sit down and discuss with a service user what they would like to do for the day, depending on their communication style the conversation might be you suggesting activities, allowing time for them to process the verbal prompt and then respond. This may be by how they position themselves – if they don't want to do the activity, they may move away, turn their back on you or simply shake their head; if they do want to do the activity they may nod their head in approval or even move towards where the activity is happening.

Signs and Symbols

Service users may associate certain objects with different things, i.e. a lunch box may indicate it's time for lunch or a picture of a bus may mean that it is time to go home. These are objects of reference. These are signs and symbols that service users use as visual aids to communication. Another example of this form of communication is a visual schedule designed around a service user's day so that they understand what is going to be happening throughout the day and they will always have a visual representation to refer back to so that they do not have to remember everything. A visual schedule can also be used alongside a 'now and then' chart to help with transitioning between activities.

Picture Exchange Communication System (PECS) is a form of communication using signs and symbols. 'PECS is a type of augmentative and alternative communication that use visual symbols to teach the learner to communicate with parents, carers, teachers and peers. The aim is to teach intentional, functional communication and to allow users to communicate their wants and needs' (Integrated Treatment Services 2021).

Technological Aids

'Technological aids, such as electronic communicators, hearing aids and videophones are designed to help people who have difficulty sending or receiving 'messages' as part of the communication cycle' (Collins Resources 2010). Service users may also use their mobile phones as a method of communication; they can use them to text their parents/guardians, family, carers or friends.

When working in a social care setting it is important to have patience and understanding when communicating with service users while they communicate with you. Rushing a service user or ignoring them because you 'don't have time' simply because you may be in the middle of another task is one way to make a service user feel you are not providing an adequate service that suits their

needs. A simple conversation may take time as the method used by the service user may involve typing out words and sentences on electrical devices. This should never be an 'inconvenience' to you as a staff member as it will most likely break down any relationship with the service user as they feel you do not care about their thoughts and needs.

Language

As a social are worker it is vital to know that your use of language will need to be altered and edited depending on the group of people or specific individual you are communicating with. An example of this is that you will likely talk to a clinician in a different manner than you would to a service user. A multi-disciplinary team is a different cultural group from the service users you support. At meetings about the needs of service users' personal plans there may be pages upon pages of information that might be too complicated or overwhelming for a service user to understand. This can be adapted and modified for them by transcribing the most important information into an easy-to-read copy that might include pictures for reference.

Ireland is home to people of many different nationalities and cultures, so as social care workers we will meet service users and families who use different languages. We must be equipped with resources to facilitate adequate lines of communication. Service users under the age of 18 and who are residing at home will be advocated on their behalf by both their parents/guardians and their service staff. In order to successfully fulfil this the family and staff must have an equal understanding of each other, language barrier included. If necessary staff may need to use an independent translator if the family do not have fluent English. It is important to not make the family feel excluded at meetings or in decision-making when it comes to care plans. Staff might learn simple and useful words and terms that are in the first language of the service user and their family. This will open up lines of communication and will build a rapport with the family so that they will understand that the staff team are putting effort into co-operating with and including the family.

In social care, language and culture are closely interlinked: 'when you learn a new language, it may not only involve learning its alphabet, the word arrangement and the rules of grammar but also learning about a specific society's customs and behaviour. When learning or teaching a language, it is important that the culture where the language belongs be referenced, because language is very much ingrained in the culture' (Day Translations 2018).

Culture

'Every time you interact with another person, you do so in relation to patterns of communication that you have learned from the many different cultural groups of which you are a member. The vast majority of those patterns will be invisible to you, and that lack of knowledge means that whilst you and others like you may judge your communication to be good, some of the most vulnerable people in health and social care settings may find it to be poor' (Roebuck 2017: 30). This may mean that when you are communicating with service users you will need to adapt your language for them to understand. 'Language and culture are intertwined. A particular language usually points out to a specific group of people. When you interact with another language, it means that you are also interacting with the culture that speaks the language. You cannot understand one's culture without accessing its language directly' (Day Translations 2018: np). An example of this would be that you may have to learn certain words of the language in which your service user is fluent or recognises primarily.

It is important to know that culture can define a person's level and understanding of communication. A service user may not understand certain jargon if they are from a different cultural background from staff. When dealing with someone who may be new to a service it is beneficial to assess their level of comprehension and understanding so as to provide them with a service person-centred to them, and using jargon-free language can aid this. Involving a service user in devising and implementing any support plans can make them feel as though not all control has been taken away from them. In order to do this, it is important that staff understand the way in which the service user communicates, and adapt their way of communicating to support the service user. As mentioned above, this may mean changing the language you use and being mindful of not using colloquial speech that you may use in another cultural group. You must also be able to read the service user's body language and facial expressions to determine whether or not they are following you or if they are afraid to disclose that they are having trouble understanding you. In this case, you may have to modify your language or the way you are explaining things, such as using more visual ways of communicating.

Beliefs

'Beliefs are things in life that you feel strongly about, that guide you in your daily life and are linked closely to your morals and values, beliefs might not necessarily be based on facts but our opinions and beliefs are not just formal ones, such as, what we regard as right or wrong' (Active Social Care 2010: np). Being able to communicate your beliefs with others is important and as social care workers it is important to be non-judgemental when a service user is expressing theirs.

In many ways, it can be difficult to support a service user as the staff may have no knowledge about, for example, their religious faith. If a service user wishes to actively practise their faith, staff should ensure that they have an appropriate knowledge in order to facilitate an open thread of communication with the service users around their religion. Staff may need to adapt religious literature for service users, and if staff do not have adequate knowledge it may make the service user feel that they are not being supported. Many religions are taught through a language other than English, and this can be an additional barrier that staff need to work through to be able to give the service user access to material. Staff may have to use online resources, translate them and then adapt them to the communication style of the service user. It is important to exhaust every option to solve any problems that exist due to a communication difference.

Being able to communicate right and wrong with a service user can be challenging. A non-verbal service user may use aggressive or destructive behaviour to try to communicate how they are feeling. This behaviour can all too quickly be labelled as behaviours that challenge, and plans implemented to manage these behaviours may be useless if the real cause of the behaviour is frustration because staff are not able to recognise what they are trying to communicate. In this case staff need to know the service user well and be able to correlate certain behaviours with an outcome of a demand or request. If a service user is trying to say they want a drink or they are in pain and staff do not understand, this may lead to a service user displaying certain behaviours. Staff may see this as challenging but to the service user it is their way of communicating a need or want. An ABC chart or scatter plot may be implemented to try to identify the cause of the behaviour and through this staff can identify a pattern, e.g. when the service user bangs on the counter, it is after they have held their hand out towards the press with the cups in it. This could be their way of saying they would like a drink. Work can then be done to open up a better level of communication, but the main thing to take from this is that something you see as challenging and unnecessary may be the only way a service user has to communicate.

Health and Social Care Needs

Through working within the health and social care sector it will become evident that each service user will use a different form of communication. As a professional working in these sectors it is important to familiarise yourself with each form of communication. As a key worker to service users it is important to create a communication passport for them so that no matter who they wish to communicate with, be it relief staff, new staff or family and friends, that person will have an understanding of their preferred way of communicating and also will allow the person to adapt their communication in a manner that will open the lines of communication with that service user.

A communication passport is a folder devised by the service user and their key worker.

Communication Passport
• The purpose of the communication passport is to provide information on how the service user communicates.
• Each communication passport includes the name of the service user and a photograph of them. This is to ensure that if someone is new to the service and is still getting to know the service users by name, they can quickly identify the right communication passport.
• The communication passports include a list of important contact numbers such as the service user's family, residential phone number, day service phone number and any other important numbers.
• The communication passport is written from the perspective of the service user, so it has a personal feeling.
• The passport will include the way in which the service user communicates. For example, if John uses Lámh, the passport will include his most used Lámh signs and how to execute them.
• It would also include information such as his favourite activities and how he likes his tea. Another service user, Jane, will communicate through vocalisations and facial expressions, and her passport will be information about what the vocalisations indicate and how to help when needed.

If you are new to a service and have never met the service users before, the passport will give you important information about the way they communicate, whether that is verbal or non-verbal. If the service user is non-verbal, the communication passport may have information such as how they like to be spoken to, e.g. slow and concise words, or for staff to use objects of reference. It may also contain information such as making sure to speak slowly and clearly and give plenty of time for the service user to process the information and be able to respond. If a service user uses Lámh, their communication passport may contain a sheet of their most used Lámh signs and ones you would need to know. It is important to learn and use these when communicating with a service user. The more you work with a service user the more you will get to know them and will be able to identify facial expressions and body movements as a form of communication.

Communication is so important when it comes to supporting the service user's needs and wants. Involving a service user in decisions about their care is vital in putting that service user at the centre in all planning and they may be able to challenge some decisions about their care that, without modified or adapted communication, would have just been implemented on their behalf. Depending on the service user and their ability to comprehend certain aspects of their care, a decision may have to be made without their input, such as decisions on medications assigned by doctors, but staff can still keep the service user informed and up to date by having key working sessions in which they communicate the information in a way the service user will understand.

To be able to provide effective services, it is imperative to be able to communicate with service users to build a strong working relationship, but to also be able to advocate for their needs and wants. This will essentially mean having a basic knowledge of many forms of communication to be able to support a range of different service users' needs in a variety of different settings and situations.

Make a service user feel important by giving them the time they need to have a conversation with someone who knows their method of communication. In a busy unit it can be very difficult to always give each service user your undivided attention for long periods of time. This is through no fault of the social care workers; there may be more service users than staff and certain service users' needs may be higher than others, which may mean that they receive more attention. However, you must be able to make it clear that if a service user approaches you to communicate they will have your undivided attention and that you will make them feel that they are being listened to. This is essential when a service user uses an alternative method to communicate.

Effective communication is essential because it supports the social care relationship. Communication is not only speaking, writing or non verbal, it is also centred on active listening. Active listening may appear a simple task, but active listening requires engagement at all levels: socially, emotionally and psychologically. Through active listening we can identify if we need to modify and adapt communication methods and styles for each service user.

Tips for Practice Educators

Make a communication passport for your service users if the service does not already do so and involve them in the process.

Research different methods of communication online, e.g. Lámh, ISL, PECS, Rapid Prompting Method (RPM), etc.

Identify an opportunity to help a service user to develop and enhance their way of communicating, such as using an electronic device, to enable them to be more independent when in the community.

As part of a learning task, get students to gain mastery over their own non-verbal cues

Communicate ethically sensitive practice.

In supervision, review with the student their communication styles and methods.

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Chapter 26 – Vicki Anderson

Domain 2 Standard of Proficiency 3

Recognising service users as active participants in their health and social care and be able to support service users in communicating their health or social care needs, choices and concerns.

KEY TERMS

Active participation

Human rights-based approach

Everyday practices and relationship building

Environment – emotional, cultural and structural

Social care is… the profession that has the most potential for impact on the lives of people in crisis. That is why it is so important to make that impact a positive one.

TASK 1

Describe a time when people did not seek or take on board your input in a decision that impacted your life. How did that make you feel?

At first glance, this proficiency appears to be straightforward: simply ask for service users' input and take their views on board. In asking for input, we need to consider and make allowances for communication difficulties, disabilities, language and cultural barriers. However, such a simplistic interpretation is problematic and lies at risk of 'tick box' practice. Does offering a choice of three activities from which to choose satisfy the requirement? Will hiring a translator suffice? Such gestures may contribute little to supporting active participation unless they are built on strong foundations that embed specific values and approaches into all aspects of the service delivery. In the absence of a human rights-based approach that respects service users as autonomous individuals with rights of self-determination, measures such as these will fall short of ensuring active and meaningful participation or decision-making on the part of the service user. These foundational approaches and values must be at the base of all service delivery, including planning, consultation, relationship-building, practice culture and everyday interactions. To effectively support active participation, consideration must be given to the power balance in staff-service user relationships. We as practitioners must fully adopt non-judgemental attitudes and relinquish control over actions and outcomes. In asking for service user input we must not only listen but must also create an emotional, cultural and structural environment where individuals are free to communicate their needs and feel safe to raise concerns.

Active Participation, Self-determination and a Human Rights-Based Approach

'Nothing About Us Without Us' (Charlton 2000).

The concept of active participation marries well with a human rights-based approach to service delivery. Both a human rights-based approach (HRBA) and the concept of active participation focus on the inherent dignity of the human being. The individual is placed at centre stage of all decisions affecting them and, most important, they play a key role in service planning and delivery (Quin *et al.* 2002).

The slogan popularly used in disability rights advocacy comes to mind on thinking about this proficiency: 'Nothing About Us Without Us' (Charlton 2000). Emerging from decades of struggle against oppression and treatment that did not recognise and respect those with disabilities as equal citizens, this slogan neatly sums up a call for control. It represents the request for respect and recognition for the rights of people with disabilities to make their voices and their choices heard and to have sufficient control over decisions that affect them in all areas of life. Though concise, the phrase highlights clearly the impacts of power imbalance, the very basis of oppression. As Charlton states, 'The needs of people with disabilities and the potential for meeting these needs are everywhere conditioned by a dependency born of powerlessness, poverty, degradation and institutionalization. This dependency, saturated with paternalism, begins at the onset of disability and continues until death' (2000: 3). Although with unique experience, people with disabilities are not alone in their encounters with oppression, both historically and currently. It is a situation all too common among social care service users that they experience powerlessness, their opinions and choices are not what determines their outcomes, and they have little control over what will happen in their lives. This is a reality that must change and as social care workers we play a key role in influencing this change both through advocacy and in careful reflection and adjustment of our practice.

What may seem like mundane and inconsequential everyday practice plays a key role in fighting or reinforcing oppression. We as a profession must adopt practices that recognise and respect the rights of service users. We must remain aware of the conditioning and paternalism that potentially exists within organisations and structures and strive to equalise power imbalance in all decision-making. We must encourage practice that facilitates service users to identify the 'problem' for themselves and to determine their needs in relation to the situation. Furthermore, individuals must be respected and supported in their decisions in utilising services and overcoming their problems, whatever the opinions of the professionals involved. A right to self-determination is recognised, allowing individuals to select their own goals and work towards them in a manner of their own choosing.

Easier said than done – discussion of self determination

Respecting people's right to self-determination can be challenging and may force us to put aside our views or even our personal values. It is easy when service users make decisions and goals we agree with, but what happens when a homeless individual decides that they do not want to engage in a programme of education and training or secure a job despite the continuing impact that it will have on their living situation? Or what if a mother decides she does not want to engage in a drug treatment programme despite her children being taken into care? How easy is it for us to facilitate active participation and self-determination at that level?

Incorporating concepts of active participation, respect and a rights-based approach into practice is complex Practice that is in line with these ideas cannot be directed and followed in a step-by-step manner; neither can their requirements be met in a half-hearted way. They are constructs that must be understood and fully embraced by the social care work team and the wider service in order to efficiently impact practice. They represent an epistemological standpoint that determines professional social care workers' practice approaches, their viewpoint on situations and, crucially, how they regard service users. This proficiency links closely with Proficiency 11 under Domain 5 (see Chapter 75), which considers active and meaningful engagement on the part of the service user. What is considered to be meaningful engagement and participation can only be determined by the individual service user involved. What is important to them? What approaches are in line with their ability and wants? What is their interpretation and understanding of the situation? It is not the role of the social care worker to determine what actions meet the requirement of active participation. It is the role of the social care worker to facilitate the individual service user to determine that, to create an environment in which they are safe and supported to express their views and are respected in their decisions as much as possible.

The role of the social care worker must also be supported by the team, managers and the wider organisational structure. Human rights values must be embedded throughout the service and easily identifiable in all areas of service delivery. It is vital that the culture and structure that surround the service users reflect these values, allowing and encouraging service users to actively participate in their own social care service.

Supportive Environments

Respecting individual service users, their rights, choices and opinions must be an aspect of the organisational culture running from the top levels of management to every person involved in the service. The relevant values must be adopted throughout the service and reflected in policy and practice as well as in planning. Only where these values are intrinsic in the service will the correct environment be provided for the service user to effectively communicate their preferences and to actively engage. Evidence of these inherent values should be visible in the visions and mission statements of the organisation, in its strategic focus and, crucially, in its planning and organisational processes. Good practice in this regard is seen where service users are recognised as key stakeholders, where they are an integral part of the review and planning process and thorough consultation is carried out in seeking their opinions and feedback. Facilitating this practice requires a division of power unusual in governance structures. While customer consultation is common in most non-care services, attributing decision-making power to customers is not. What is required is that the traditional model of top-down service delivery is flipped to allow for a bottom-up approach. Adopting this partnership approach for strategic design is a difficult process and requires that all involved are dedicated to the values at the heart of the change. Power division must be structurally embedded, with clarification of roles and processes to support continued active and meaningful engagement. Clear lines of communication for feedback, review and raising concerns or complaints must be in place. Service users must know the ways in which they can get their message across

and feel comfortable and confident to do so. All service staff must actively seek out opinions, views and feedback from everyone in the service. Representatives of service users should be active in planning and review teams.

TASK 2

Consider different environments that you encounter. Which of those environments encourages you to speak up for yourself and communicate your choices? What about that environment helps that to happen?

For these efforts to be successful, respect for active participation must also be a cornerstone of the organisational culture. Reflection in organisational visions and missions will support this, as will the modelling of good practice by management. However, further efforts must be made to ensure that appropriate values are adopted among staff teams through training, education and supervision. These aspects of practice culture should be protected through continuous review and reflection. In absence of these cultural and structural supports, the individual social care worker will be challenged in incorporating them fully into practice and the service users will not feel the full benefit. Being proficient in supporting active participation is therefore not only associated with service user interaction, it also requires the social care worker to be able to identify the absence of necessary structural aspects and to advocate for change.

Everyday Practice and Emotional Culture

Recognition of service users as active participants in their health and social care is not only relevant in direct planning situations, it must also be an aspect of everyday practice and inherent in all interactions and communications with the individual. In fact, when facilitating active participation and consultation, these practice domains are not mutually exclusive. This proficiency requires professionals to support service users to engage in planning processes, to contribute meaningfully to determining their care plans, their goals and, as much as possible, the frameworks of their health and social care. Efforts in this regard will be minimally effective in large planning operations if they are absent from smaller-scale planning and communication. The necessary recognition and respect must be at the base of the service user-social care worker relationship and must be present in the seemingly meaningless interactions of everyday practice. To be effective, this proficiency must not only relate to the determining life goals, it has to be present in deciding on the plan for the day or in deciding what's for dinner. Furthermore, these smaller decisions must be respected, the rights of the service user to make these decisions must be respected and this respect must be communicated consistently. The reasons for this are threefold.

Everyday actions: it must be recognised that life is not made up solely of long-term and large-scale planning; life is determined by the small everyday actions and interactions that each of us has. If service users are not participating in decisions daily, they are not sufficiently active. Unlike many other professions, the impact of social care work is not reserved for scheduled appointments or meetings, it is carried out through everyday activities and interactions that from the outside may appear insignificant.

Have an Impact: it must be appreciated that the purpose of this proficiency is not solely that a professional has the relevant recognition of the service user, it is that that recognition is felt and observed by the relevant person or persons. It is important that the recognition on the part of the social care worker has the necessary impact on the life and experience of the individual service user. As stated above, the relevant respect for and recognition of the service users' right to participate cannot be portrayed in a half-hearted manner, it cannot be faked. If transmission of this proficiency is reserved only for a formal planning environment, it will not hold sufficient weight. It can only be meaningful where it is communicated to the service user in small, everyday interactions. These interactions are the site for professional relationship-building, where the parameters of trust and respect are built, and where the majority of the social care work is carried out. It is through the small daily interactions, the shared meals, chats over tea or seemingly meaningless trips to the community that the emotional environment of the service is established. It is vital that this emotional environment is one that respects each service user and supports them to express themselves and to communicate freely without fear of rebuke or judgement. Honest communication about needs and wants, and particularly concerns, requires a sense of emotional security, which takes time to establish. For this reason, showing recognition of the service user as an active participant in their health and social care must be ingrained in all areas of practice and service delivery.

Supports Service User to Communicate. The third aspect of this argument links into the second section of the proficiency, directly addressing communication. The proficiency requires that the social care worker supports the service user to communicate their needs, choices and concerns. Communication can be a challenge in several social care sectors. This may be due to inhibited communication skills, disabilities, language or cultural difficulties, among others. In these circumstances, communications are strengthened through informal everyday interactions. Both the ability to communicate and the confidence in communication are improved where the social care worker takes the time and effort to listen and to effectively support communication. Time and energy must be invested in maximising lines of communication through small, casual and everyday interactions. Only then can social care workers sufficiently support communication for active and meaningful participation.

In summary, despite the apparent simplicity, practice in line with this proficiency is reliant on understanding, appreciation and adoption of a range of inherent values, not only by the social care worker but by the service as a whole. Being proficient in this regard requires more of the social care worker than simply asking questions and using communication supports. It is the responsibility of the social care worker to understand their role and that of the service in either changing or reinforcing the systematic oppression that their service users experience and that so many have fought to change. This proficiency requires the adoption of an intrinsically human rights-based approach that recognises the value of a person, that respects their right to self-determination and places them at the centre of all decision-making. These values must be incorporated into everyday activities, they must be communicated to the service user in all interactions and must be a cornerstone of the practice culture. It is the job of the social care worker to create the appropriate emotional environment through everyday practice that supports the service user to feel safe and respected in communicating their opinions, choices and concerns. Furthermore, it is the role of the social care worker to recognise the importance of surrounding cultural and structural environments in influencing the ability of service users to actively participate in their health and social care. Where these environments are inadequate, it is the job of the social care worker to advocate for change in the best interest of their service user.

Tips for Practice Educators

Developing the necessary skills and knowledge for this proficiency requires different layers of learning for the student. While they will have knowledge of the proficiency and will have considered practical application before they come to the placement, a true appreciation of the meaning of active participation and an adoption of the relevant values into practice requires real life experience. What active participation means will be different across various social care settings, as well as between different individuals. It is paramount that the student has the opportunity to witness real life examples of this proficiency in action, to observe the adoption of the underlying values and assumptions and, most important, to see the limitations and barriers to application.

My advice to practice educators would be start early; talk to the students about this proficiency from the beginning of their placement, as reaching the adequate level of understanding may take time. Begin with supporting them to develop a baseline understanding of how they see service users being supported to make and communicate their choices day to day. This could be as simple as choosing activities or choosing the clothes that they wear. Encourage the students to identify these things and ask them what structures they see that support or limit these types of choice.

Once you are satisfied with their understanding of the everyday practice, move to supporting them to develop a more critical awareness. Perhaps, when they know the service users a bit more, ask the student what they think active participation means to the different individuals. It may be suitable in your setting to have them look at one or two service users as case study examples. Focusing on individual circumstances will facilitate the students to critically explore the concept of active participation and how they as practitioners can support it to happen, even where limitations are in place. Whether restrictions to active participation be circumstantial or resource-based, it will benefit the student to see how limitations can be minimised through professional practice that seeks to support the service users to communicate their choices and that respects their choices. Don't be afraid to challenge the student, ask them some difficult and thought-provoking questions to guide them towards a deeper level of understanding and appreciation. It is important that you use your own insight into the concept and your experience of its application in your setting for these discussions.

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Chapter 27 – Eleanor Lyons

Domain 2 Standard of Proficiency 4

Understand the need to empower service users to manage their well-being where possible and recognise the need to provide advice to the service user on self-treatment, where appropriate.

KEY TERMS

- Active participation
- Human rights-based approach
- Everyday practices and relationship building
- Environment – emotional, cultural and structural

Social care is … The ability to guide and help an individual fulfil their goal with the best possible outcome. Nothing is perfect, but within social care we can help promote change and ultimately support the individual towards success in life.

What is Empowerment?

Empowerment is a human right (Smith 2018) which is achieved through increased service user involvement, where they are supported to become independent, confident individuals in control of their own life. This chapter is written from the perspective of empowering individuals within a disability setting. Empowering any one individual brings a sense of achievement or accomplishment to the person involved. One of the many objectives as a social care worker is to empower the individual to fulfil their dreams or goals for the year. These goals may not be achievable immediately, so it the role of the social care worker to help implement a step-by-step planned process that will empower the service user to meet their needs and attain their goals in a gradual and achievable way. In the disability sector, this process is called person-centred planning.

TASK 1

How would you empower your service user to make an effective decision?

Person-centred Planning

The Health Service Executive (HSE 2018) advocates for creating empowerment cultures within health and social care settings, based on a belief that each individual should be treated with respect and dignity and should be an active participant in their own life choices and experiences. In *New Directions* (HSE 2018: 14) empowerment is one of the core beliefs of person-centred planning, along with equality, respect, dignity, independence, choice, inclusion and active citizenship. 'Empowerment; person-centred planning supports the person to take control

of their life. Each person is supported to have their say and their views are respected' (HSE 2018: 14). During the course of making a care plan or a person-centred plan, the individual will work with their 'key person' to document what goals they would like to achieve during the course of the year.

The main aim of the person-centred plan is to get to know the service user and understand their needs and wishes for the future. Throughout the meeting, the key person and the individual will design these goals in achievable steps. This process will support the individual to successfully develop new skills based on their wishes and desires. The diagram illustrates the three themes that are discussed during the planning stage. The individual is supported to communicate what they enjoy and what hobbies and interests are part of their identity (MY SELF). MY WORLD is an opportunity for the service user to describe all the people, places and experiences that are important for them now; and MY DREAMS is all the wants and wishes they have for their short-term and long-term future. According to Sanderson (2000), the key features of person-centred-planning include active listening (in order to learn about the person), so people are encouraged to say what they want; and gathering key people together to put the plan into action. The following table, adapted from Sanderson (2000), lists what person-centred planning is and what it is not.

Person-centred planning is about:	Person-centred planning is not:
× Listening to and learning about what people want from their lives	× The same as assessment and care planning
✓ Helping people to think about what they want now and in the future	× The same as reviews
✓ Family, friends, professionals and services working together with the person to make this happen	× Owned by services
✓ A commitment to keep learning about the person	× Just a new type of meeting
✓ For everyone who wants one	× Only for children or adults who are 'easy to work with'

Different social care organisation will have alternative approaches to person-centred planning. Whatever the title used, a person-centred plan places the individual at the centre.

So who attends the person-centred planning meetings? The individual will write a list of who they want to invite to the meeting, who may include a parent/guardian, sibling, family friend and any professional that works with them and is important in helping them to put this plan into action.

Source: Sanderson (2000)

During the course of the meeting, the individual is given an opportunity to express what they want, explain how they are feeling and discuss how they want to fulfil their goals. For the non-verbal service user, creativity is used as a way of supporting them to express their goals and wishes in alternative ways. The person-centred planning process also aims to improve the service user's self-efficacy and increase their self-confidence. Towards the end of the meeting, each individual who was invited communicates what they have understood from the meeting and shares how they can support the service user to meet their needs and achieve their goals throughout the coming year. As well as achieving goals and meeting needs, an empowerment culture (HSE 2018) can help service users gain confidence to manage their own wellbeing, where appropriate, through the support of social care workers, the staff team, family and friends.

In day services such as training centres, the staff would work towards employment for the service user to achieve independence and empower them to work in the community base. Working in the community helps the service user to feel involved and gives them a sense of belonging. To begin with, they would have someone working one-to-one with them during their working hours. Once the individual has been trained, they will continue to have a worker alongside them, to help them if they have any issues. It is important to note that the whole process of the service user attending work should be designed during their person-centred meeting. Any areas that may need improvement or what may be a concern should be highlighted and discussed, along with the supports to be provided.

TASK 2

For more information on person-centred planning, please read the HSE's *New Directions: A National Framework for Person-centred Planning in Services for Persons with a Disability* (2018).

Wellbeing

The proficiency in Chapter 20 focuses on the responsibility of social care workers to take responsibility for their own health and wellbeing. In her chapter, Karen Mahon presents the WHO (2014) definition of health as including physical, mental and social wellbeing. This chapter is focused on how we can empower our service users, where appropriate, to play an active role in managing their own life and health, including their physical, mental and social wellbeing. Heslop and Hebron (2020) also adopt the WHO definition, presenting happiness as related to their view of health and wellbeing for people with an intellectual disability. This view of wellbeing acknowledges 'a relationship between an individual and the social and environmental factors that determine their health' (Heslop 2020: 4). Based on my practice experience this can include making the individual physically and emotionally comfortable by helping them to feel safe and loved, and promoting their good health by supporting them to make healthier choices. Other factors that can contribute to wellbeing and happiness include social contact, level of loneliness, how easy it is to get outside and be in open spaces or have opportunities to connect with people (Heslop 2020).

Working in social care, self-awareness of our own wellbeing and a knowledge of wellbeing strategies can help us to empower the individual to have a balanced outlook, to help them make healthier choices, to increase their happiness and help them through experiences such as physical or emotional trauma. As professionals, we have a duty of care to make sure the needs of the individual are met to a high standard of care and that they play an active role in managing their own health.

Empowerment is only achievable through a relationship of trust developed between the service user and the worker. It is the role of the worker, through this relationship, to provide advice to the service user on strategies and ways they can improve their health and happiness. The HSE's New Directions policy (2014) discusses consent as an ongoing process in which the service user is asked for their consent to be supported, when possible and appropriate.

TASK 3

Please read Chapter 16 on the current legislation and guidelines related to informed consent for individuals with lack of capacity.

Consent/Self-treatment

Part of social care work is to provide advice to the service user on strategies and self-treatment options to improve their overall health and wellbeing. Guided by the HSE's National Consent Policy (2019), when they have capacity to sufficiently understand the information and consequences of any decisions they make, their consent is needed. The individual can express their consent in writing, orally (speech) or non-verbally (nodding or hand gestures). Social care and health professionals must give the service user enough information in a way that they can understand and decide whether they do give consent. The service user's decision must be voluntary and made without undue pressure to agree or disagree. Also, the service user must be mentally capable of communicating their decision to the social care professionals or any other health care professional, as per the Assisted Decision-Making Capacity Act 2015. This Act set out a system for adults who may have difficulties with making an important decision to have the support to make an effective choice (Inclusion Ireland 2021). In some situations, a ward of court is appointed to guide and outline consent for an individual making an important decision. The relationship between the services (health and social care) and the service users should be developed on the basis of trust and good communication. Good communication requires all parties to recognise and acknowledge the service user's goals, their values and choices, along with guidance from the health and social care professionals (Inclusion Ireland 2021).

If the service user needs to attend treatment outside the service, the social care worker should outline to them what the appointment is for and why it is important to attend. A recent Health Information and Quality Authority (HIQA) inspection outlined the importance of the service user having a consent sheet to sign to confirm that they understand why they are at the appointment and that they can stop at any time. Before any medical treatment, such as attending hospital or the local GP, the service should ask for the service user's consent. Depending on the situation, the service user's next of kin or social care worker will be present at all times.

Case Study 1

John is a 35-year-old man living in a residential house in Dublin. He has mild Down syndrome and over the last year has developed a lung concern. Staff called his local GP for an appointment as John's breathing has deteriorated. When John arrived at the appointment he refused to go in as he was not sure what the appointment was for and wanted to speak to his brother Sam. Staff explained to John the importance of the appointment and explained to Sam (John's next of kin) that staff were concerned about John's health. Sam asked to speak with the manager of the residential house to get a clear picture of why John did not have an explanation of the importance of the appointment before attending. The manager apologised for the lack of communication and John not being informed of the medical appointment taking place. A policy was drawn up that all residents in the house would sign the consent form and be informed about the medical appointment before attending.

Adults with intellectual disabilities, depending on their mental capacity, can orally consent and express how they feel. Children and adults with an intellectual disability could use 'easy reads' to help explain the appointment and help the service user to feel empowered in the process of taking responsibility of their own health and well-being. Supporting the service user to become an effective decision-maker in their own health and well-being is another important role of social care work.

So how do we empower the service user to manage their wellbeing and provide advice to the service user around self-treatment?

As social care workers we have a role, through person-centred planning, to empower the service user to build meaningful relationships, be empowered, and give informed consent. This chapter has explored the different elements that we face every day working on the frontline and dealing with the ongoing issues that the service users will face. We do not have all the answers, or the best strategies to use, but we have the ability to sit and listen to the service use and to advise them on the best actions to take.

Tips for Practice Educators

During the student's time on placement, a discussion group could help ease them into their new role in the social care setting. The discussion group will help release nerves and tension and break the ice, helping all involved to build a professional relationship.

Beginning placement: At the beginning of a placement, it is important to give the student different jobs to undertake and make them feel involved in the social care setting. The jobs could be small, but this allows for casual chats between the service users and the student on placement. From here, a relationship can develop over a cup of tea or coffee, along with building common interests between the student and service user.

During placement: Once the relationships have begun to develop, the student can take on more responsibilities, based on the abilities that they have shown over the previous weeks.

1. Undertaking an activities that would benefit the service user. For example, designing a wall area about what interests the service users, e.g. a television programme or music.
2. Use a computer to choose colours and work out how the design will be placed on the wall. Each service user has their own part of the wall and their part of the wall will represent their own ideas.
3. The wall design is a talking point for each service user to express how they see life and allow conversation to develop.

How can the social care worker guide the individual student on placement?

First, sit down with the student and get to know them over a cup of tea or coffee. This will give the student the opportunity to ask questions about the service and what their role will be for the next 12 weeks.

Outline what the social care role is within the service, what their job will be and how their role is important in empowering of the service users.

Explain that service users learn by watching the social care workers and being shown how to complete a task.

No question is a silly question – so ask the question! For example, 'How can I help the service users manage their wellbeing and grow?'

The smallest impact can bring great achievements and empower the service user, with support, to fulfil their goals.

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Chapter 28 – Deirdre Berry

Domain 2 Standard of Proficiency 5

Be able to recognise when the services of a professional translator are required.

KEY TERMS

Cultural diversity

Cultural diversity in domestic violence services

Gender-based violence

Lost in translation

Who should translate?

Social care is … the provision of care to vulnerable and marginalised groups of individuals in our society. Social care workers advocate, guide and support their client groups. Social care incorporates a wide range of service provision, based on the principles of respect, dignity, inclusion and empowerment. To achieve the best outcome, social care workers must apply a meaningful and genuine interest in working towards better outcomes for a person. Social care work is not about just providing care but also being caring. It is the skill of developing relationships while maintaining boundaries.

Cultural Diversity: The Changing World We Work in

The people of Ireland are scattered all over the world; many Irish people have migrated to other counties during times of famine, war and economic crisis. Irish society has become increasingly diverse, as many other nationalities have migrated to Ireland to live. In April 2020, there were an estimated 644,400 non-Irish nationals resident in Ireland, originating from 200 different counties, and accounting for 12.9% of the total population (CSO 2020). This creates a vibrant melting pot of cultures, languages, religions and experiences. In Ireland, unlike countries such as Australia that have specific written guidelines in place for the provision of interpreting and translation, there is a lack of written policies for government departments and agencies and a lack of guidelines for staff on when and how to use interpreters. This is not to say, however, that there is a complete absence of policy, as there are obligations under the European Convention on Human Rights, which must be adhered to for legal process; the Refugee Act 1966; and, more generally, the Equal Status Acts 2000-2004.

Social care, in its essence, is a body of trained professionals who plan and provide quality care and support to vulnerable individuals and groups of all ages experiencing marginalisation, disadvantage and/or special needs, irrespective of their culture or language. Social care work utilises problem-solving and task-centred approaches, which guide and advocate for service users to support, empower and sometimes challenge them to overcome diversity. This can become more complex when service users speak a different language. To do this work, social care workers use a suite of tools and communication skills including body language, tone of voice, eye contact, touch, the written and spoken word. Providing accessible information in a range of user-friendly formats to all service users is an integral approach to service delivery in every social care setting. Such information assists those who may not be functionally literate, may have hearing or sight impairments, may not be competent in the English language, or who may need information presented in plain English. The principal objective of the social care worker is to support service users to reach their full potential and sometimes this might include knowing when to enlist the services of another professional. Speaking a different language, or lack of access to a professional translator or interpreter, should not be a barrier to people getting the support they need.

SOME TOOLS AND TIPS THAT CAN HELP WHEN LANGUAGE IS A BARRIER
• Google Translate can be used for immediate translation in a crisis response or to translate a message.
• Some services have translation services: hospitals/the Gardaí/courts have interpreters they can access. Women's Aid has a translation service, which can be accessed through its helpline: 1800 341 900
• HSE Multilingual Resources and Translated Information can be found on the HSE website, with many translated leaflets available.

TASK 1

Talk to someone in your class, workplace or community for whom English is not their first language. Use Google Translate to translate a sentence from English into their first language and ask about the accuracy of the translation, and what information is lost in the translation.

INTERPRETERS

An interpreter converts information from an oral or sign language into another language, as a means of enabling communication between two parties who use different languages.

A TRANSLATOR

A translator carries out the same task with written information.

Interpreters and translators can help us understand our service users, accurately ascertain their needs and appropriately communicate professional opinions and relevant information about their care. An interpreter speaks more than one language and can help to communicate with services users when English is not their first language.

Cultural Diversity in Domestic Violence Service

I have worked predominantly, in frontline and management roles, in the area of gender-based violence (GBV), within a domestic abuse support service for women and children. It is mainly a crisis intervention service. I will draw on my experience of this setting throughout this chapter to give practice scenarios of working with families when English is not their first language. If you are unfamiliar with the work we do, I have included the following short segment.

Case Study 1

Background to a Domestic Violence Service

The service I work in provides a 24-hour helpline, emergency refuge accommodation, outreach and court services and a specialised children's service to women and children. However, as well as supporting women and children directly we also provide specific expertise in safety planning; connect and accompany women through medical, legal, financial, immigration, employment, educational and social services; and provide direct care to traumatised women and children in refuge and other residential settings. We also work to challenge organisational policies, institutional values, and/or public attitudes to improve system responsiveness to women in abusive relationships. We provide training to partners such as gardaí and other civil service personnel, design public relations campaigns, and talk to students in local education systems. Logical reasoning and problem-solving is at the core of our practice every day. It is a service user-led service, which essentially means that every person who enters the service gets a bespoke service. This is key to our work as every person is unique and has had unique experiences and needs. Historically, most of the domestic violence and abuse services in Ireland have been developed from a grassroots response to the needs of women and children in communities to a nationally organised response. The services were developed as survivors and advocates lobbied for responses, services and pathways to safety for women experiencing violence in their home. In recent years Ireland has evolved in its provision of responses for people experiencing domestic violence with the Domestic Violence Act 2018 replacing the Domestic Violence Act 1996 and the Domestic Violence (Amendment) Act 2002. This brought positive and significant changes, many of which have been petitioned for by domestic abuse advocates for a long time. Changes in guidelines, such as extension eligibility for orders and intimate relationship being considered an aggravating circumstance in sentencing, were introduced, ultimately improving the protections available to victims of domestic violence under both the civil and criminal law. Moreover, from January 2019 coercive control became a criminal offence in Ireland. This development gave recognition and grounding to the destructive patterns of abusive behaviours. The standardisation and professionalisation of the domestic abuse sector has also opened the door to the social care sector, with many services modelling their service on the social care model. In fact, social care is the discipline that is most sought after in the domestic, sexual and gender-based violence (DSGBV) sector.

Social care workers are part of the multi-disciplinary team within domestic abuse support services.

Over the past 15 years I have supported many migrant women. Coming to live in a new country is filled with many hopes and challenges; a new language, opportunities, different social policies, little or no family or social support systems, status, to name a few. Facing everyday challenges without a support network can easily lead to difficulties. This is where the social care service (care homes, homeless services, family support, addiction supports and mental health services) will meet many migrant persons facing adversity. Some migrant women may not have travelled willingly, may have been trafficked or misled into a false promise of marriage, employment or a life free of war and hardship. Those who seek asylum in another country may have experienced war, conflict-based rape and/or rape, abuse and terror in their country of origin or during the migration journey. I have witnessed women arrive to the refuge door, some with small children, some older women, some women who are still in their teens, who are afraid, upset, hurt, confused; they are traumatised. Their situation becomes a lot more challenging when they have little or no English.

Gender-based Violence

All genders can experience domestic abuse. I work specifically, in a gendered approach, with women and children, therefore my practice reflection will be through a gendered lens of my work with women and children. Gender-based violence (GBV) is one of the most prevalent social problems in the world. Not only is it a violation of women's human rights, but it also has devastating physical and psychological health consequences for victims/survivors (WHC 2007). It is complex in its various forms (physical, emotional, financial, sexual, social and coercive control); additionally, other difficulties can add to its complexities, such as mental health, addiction, cultural and religious beliefs and socio-economic background. All of which can be barriers to safety. European research suggests that one in three women (33%) have experienced physical and/or sexual violence (FRA-EUAFR 2015). Women's Aid reports that one in four women in Ireland who have been in a relationship have been abused by a current or former partner. While all women are at risk of experiencing it, a range of factors place minority ethnic women at higher risk than the rest of the population. They include the twofold discrimination of gender and ethnic origin, migrant status, increased isolation and social norms that are defined by patriarchal values. Some minority ethnic women come from cultures where harmful traditional practices are carried out, such as female genital mutilation (FGM) and forced marriage.

While services in the DSGBV sector provide specialised services, domestic abuse and violence will, due to its prevalence, commonly present as an issue in most social care settings. For example, in residential care, domestic abuse could have been a presenting issue in the child's family of origin; in youth work, patterns of abusive or unhealthy relationships may surface and support or educational programmes may be necessary. The double discrimination of gender and racism has created a situation in which minority ethnic women are not always able to access the services they need. In addition, their economic and social circumstances, as well as migration and residence laws, may militate against their ability to access services. Additionally, living in a home where there is domestic abuse and coercive control can make a person feel extremely isolated and afraid. Not being able to speak the common language and an absence of interculturally competent services exacerbates this and leaves the person in a very vulnerable situation. For many migrant women, when they reach out for help, it is when things have come to a very difficult and dangerous point.

Lost in Translation

BE MINDFUL OF CULTURE

- Your presence and their personal space
- The person may be afraid and may have been told not to trust others, particular persons in authority, gardaí, medical services.
- Gender and cultural norms
- Past and present trauma

As social care workers we rely on our humanity to connect with people. We then deploy our skills and knowledge to support the people accessing our services. In those moments of crisis, when a person reaches out for help, we must respond by de-escalating the situation enough to act effectively.

De-escalate the situation:

- Show empathy and provide reassurance
- Remain calm
- Help them self-regulate (sit, breath)
- Offer caring gestures (tissue, drink of water/tea)

Assess the situation:

If the person is traumatised, the social care worker must assess if the trauma is a factor in their ability to communicate. Trauma can impact people in different ways. A person may present stunned, non-verbal, withdrawn, distant, confused, upset or crying, rambling, confused, shouting, talking rapidly, frustrated. Once the person is somewhat calm and can start to communicate, the social care worker must figure out if they can understand some English. Establishing names, country/language they speak is a good starting point. It may not be possible to get an interpreter in that moment so using other communication tools can help provide reassurance. Google Translate/translation apps on mobile devices are helpful. As there are so many language variations, even within one country, Google Translate can help identify the specific language spoken, which will assist when arranging an interpreter.

Within many social care settings, for example a refuge environment, assessing health and wellbeing may need to be the first response. If a person presents with visible injuries medical assistance should be provided. However, in the context of domestic abuse some injuries may not be visible, if the person has been sexually assaulted or assaults are intentionally not carried out on obvious or visible areas of the body. Be cautious if offering other services; this may frighten the service user, especially if they do not understand the context of the conversation or if their status in the country is linked to another person.

Who Should Translate?

If there is any doubt that the person does not fully understand the conversation, a translator should be enlisted. Some people who are frightened and unsure may give the impression that they know what you are saying. Clarity and understanding should be sought. Be aware that service users may not want to use an interpreter and may prefer to use a family member or friend. Children can often become language brokers for their non-English-speaking parents. Using children to interpret should be avoided. Children must be protected from harm, as outlined in Children First guidelines, and interpreting may cause distress and trauma for the child. Using adult family or friends has its advantages and disadvantages; additional information may be shared if family members interpret for one another; service users may mistrust using an unknown professional interpreter (Lucas 2014). Nevertheless, issues of collusion and accuracy have been identified when informal interpreters have been used in public services, resulting in errors and compromised meaning (Lucas 2015; Dorner *et al.* 2010). In the case of domestic abuse disclosures, some service users may not want to disclose details of their abuse, to protect the friend or family member or because they feel ashamed. There are also concerns about interpreters' availability and confidentiality breaches (Sawrikar 2013). This may present in small tight-knit communities. One example of this occurred when the court interpreter was known to a woman I supported. This woman was applying for a domestic violence order. The incident caused huge distress for the woman, and resulted in her withdrawing from accessing the court order for protection. This also left her in an unsafe situation, worrying if the interpreter would tell her partner of their encounter.

KEY PRINCIPLES for the Interpreter

Confidentiality, impartiality, accuracy, competence and non-discrimination.

Interpreters contribute to assessment and intervention processes by facilitating communication, and by doing so, they gain insight into service users' experiences, perspectives, wishes and feelings. Discrimination and oppression are common experiences for emergent bilinguals, thus facilitating communication is an anti-racist and anti-oppressive practice issue. Ensuring that services are provided in a suitable format and facilitating communication is helpful in recognising people's language, history, culture, traditions and religion (Keating 2000). Using an interpreter when language is an issue is important to ensure understanding and gain clarity. This is particularly important when completing risk assessments, informing service users of their rights, in child protection issues, for consent to engage in services or share information to other services, and in line with General Data Protection Regulations (GDPR).

For example, information for a woman accessing a refuge in crisis:

This is a refuge, women and children who are hurt or afraid at home can stay here. You are safe here. I work here, and it is my job to help you. If you are afraid, we will not tell anyone you are here.

Can you tell me how I can help you ...

Engaging the services of an interpreter can be time-bound. Whether over the phone or in person, the interpreter will have a set time with you to provide their services. Preparation for this will ensure the time is used effectively. Write down the information you need to provide to the service user and write down the questions you need to ask them.

Be mindful that you can enlist an interpreter again, at a later stage, so do not overwhelm the service user with too much information. Keep the information specific and deal with the most pressing issues.

It may help to clarify at the start of the first meeting that the interpreter is a professional doing their job, has no decision-making powers and is bound by the confidentiality policy of the agency. Speak directly to the service user, rather than to the interpreter. Many more sessions may be required as the service user's needs are identified. Once the crisis point has passed, communication will increase as trust and the feeling of safety grows. For more practical tips for using translation services see the resources listed at the end of this chapter.

Funding and access to translation services or an interpreter must be considered. Some partner services have access to these services; however, all services should work towards having their information translated into the most used languages. Services should also have guidelines for staff detailing when and how to enlist translation and interpreter services.

Conclusion

Our society is growing rapidly and with this growth diversity blossoms. Our social services must be able to support all persons in our society. Communication and Language is the seed that must be present in order to assess and meet the needs of all persons. Every person has the right to have their voice heard; it is up to us to enable this process, to support and ultimately assist them to overcome the adversity they are facing. Engaging and working with other cultures can create learning and new experiences that enrich services and the people in them. Having services that are accessible to all persons ensures inclusiveness and diversity. Training staff in diversity, equality and inclusion can help build awareness of unconscious bias, cultural competence, or other barriers to diversity, equity, inclusion and belonging. It can also motivate positive behaviours and attitudes. Reflection and sharing learning can also add to this growth.

Useful recommendations for interpreting and translating services:

1. The National Consultative Committee on Racism and Interculturalism (NCCRI) report, 'Developing Quality Cost-effective Interpreting and Translating Services for Government Service Providers in Ireland' (2008),
   https://www.translatorsassociation.ie/wp-content/uploads/2019/08/National-Consultative-Committee-on-Racism-and-Interculturalism-Developing-Quality-Cost-Effective-Interpreting-and-Translating-Services-2008.pdf
2. HSE Multilingual Resources and Translated Material Information,
   https://www.hse.ie/eng/about/who/primarycare/socialinclusion/about-social-inclusion/translation-hub/multilingual-resources-and-translated-material/
3. Lost in Translation? Good Practice Guidelines for HSE Staff in Planning, Managing and Assuring Quality Translations of Health-related Material into Other Languages,
   https://www.hse.ie/eng/services/publications/socialinclusion/lostintranslationreport.pdf
4. On Speaking Terms: Good Practice Guidelines for HSE Staff in the Provision of Interpreting Services,
   https://www.hse.ie/eng/services/publications/socialinclusion/emaspeaking.pdf

Tips for Practice Educators

Working in the DSGBV sector can be both challenging and rewarding. Student placements in this setting can yield rich learning not only about domestic abuse but also in many interconnecting areas of social care, such as social policy, as we support the service users through social welfare, housing and immigration issues. It also exposes students to the legal and justice processes, navigating working with the Gardaí, legal aid and court procedures. Students may also learn and practise risk assessing, care planning, reflection and child protection. Building meaningful relationships is the essence of our work in DV services, and within all social care settings. Students can certainly have an opportunity to practise this.

Preparation for placements

In my experience, students starting a placement in a GBV service may become overwhelmed. Walking into the setting, which is normally buzzing with families and small children, and meeting the team is the first taste of the reality of women and children fleeing their own home due to fear, violence and abuse at the hands of those who should provide love and care. Taking some time to process this before starting placement will prepare the student.

Knowledge of the law, particularly the Domestic Violence Act, and in relation to coercive control and other types of violence, is also essential.

Most GBV services will have student handbooks and student placement co-ordinators and mentors. Students should seek them out.

In our service, we accommodate students on placement from third and fourth year. We have found at this stage in their studies students have a broader learning base and the maturity needed to complete the placement successfully.

As the GBV sector grows it is opening many more employment opportunities for social care professionals, and new research and publications also allow for rich learning for students.

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Chapter 29 – Paul Hogan

Domain 2 Standard of Proficiency 6

Be able to produce clear, concise, accurate and objective documentation.

KEY TERMS

Purpose
Effective report writing
Writing in practice
A model for report writing
Holistic needs assessment

Social care is … a broad profession, characterised by the delivery of quality care and support to individuals, families, groups, communities and societies that experience challenges, adversity, disadvantage, marginalisation, isolation or any form of discrimination or oppression.

Introduction

Social care workers write reports and record information every day and in various formal practical situations. Report writing is a skill that we are expected to have from the beginning of our placement or employment, and yet there is little training or direction available, and many social care workers struggle with the challenge of writing reports.

This chapter aims to address this gap by providing an overview of report writing and record keeping for the social care worker in Ireland. The chapter is not prescriptive, but it endeavours to enable social care workers and students to understand and develop the proficiency to write effective, objective and accurate reports and records.

The ability to write clearly, accurately and objectively is an essential skill for all social care workers. It underpins quality service delivery, effective inter-agency collaboration, and best practice in terms of professional development.

This chapter will support students and social care workers to understand this proficiency and develop skills in preparing factual, structured and concise reports to serve various needs and groups. The first section will detail the purpose of effective report writing, followed by the application of a skills model before concluding with a case study. The last section gives some tips for practice educators.

The Purpose of Effective Report Writing

The purpose of report writing is to provide a permanent and evidenced account of a service user's development while in care. Reports can also be a tool for staff in person-centred planning. While supporting continuity and cohesion of practice by meeting regulatory and statutory requirements, report writing and record keeping also promotes accountability and transparency in delivering interventions. Effective report writing and record keeping also fosters a lifelong learning environment and contributes to the continuing professional development of social care workers.

The Standards of Proficiency for Social Care Workers (2017) set out the expected standards for social care professionals who are regulated by CORU. This comprehensive report determines the standard to maintain competence and performance in producing clear, concise, accurate and objective documentation under proficiency six of the Communication, Collaboration and Teamworking domain.

The ability to produce clear, concise, accurate and objective documentation is a key social care work proficiency, but one in which students receive little formal training and preparation (Webber 2015). Reports and records that social care workers need to produce include assessment reports, daily case reports, family communication plans, access reports, care plans, daily diaries and reflective practices, etc. The social care sector is developing a growing reputation for increased administration, resulting in greater demands for social care workers to master the skill of writing reports. It is also important to be familiar with the organisation's in-house policy on key tasks such as report writing, safeguarding, data protection and referrals to other statutory, regulatory and professional bodies such as Tusla, HIQA, An Garda Síochána, and members of the legal profession.

Although this chapter does not expand on legislative requirements in relation to report writing, it is important to be mindful of the statutory provisions under, for example, the Freedom of Information Acts 1997, 2003 and 2014; the Data Protection Acts 1988 and 2003; the General Data Protection Regulations 2018; and the Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Act 2012. Effective report writing involves good communication skills, having an active rather than passive voice and learning to write objectively. These three important skills are essential for effective report writing.

Good Communication Skills

The ability to communicate effectively is an integral element of the ability to write good reports and it is an essential part of the role of the social care worker. There are various methods of communication, including oral, non-verbal, and written. The accuracy of the written report is essential as it may inform future interventions and resources for the service user. There is a requirement for social care workers to ensure that what they write is legible, accurate, clear and objective.

When writing reports, it is important to be aware of non-verbal communication and the need to document these in report writing. These may present as shrugs, nods, crossing arms or legs or both, grimaces, gestures, tone of voice and eye contact (Griffiths 2010). Learning to take account of these reactions is part of developing the skills of report writing and record keeping.

A report can be understood as a means of communicating an account, information or advice from a person who has collected the facts to a person who has requested the information for a specific function or the performance of a particular task (Stanton 1990). It is a short, concise document that is written for a particular purpose and a specific audience or multiple audiences, and which generally sets out and analyses a particular situation. There are three basic elements to writing reports in social care: a rights-based and service-user focus; a sound understanding of the values and principles that underpin social care practice; and competence and proficiency in compositional, rhetorical and technical writing skills (McDonald *et al.* 2015). Reports should be underpinned by social care values and principles such as social justice, partnership and equality while deploying anti-discriminatory, objective and non-judgemental language, which clearly details fact rather than feelings or opinions. Social care workers must ensure that nothing contained in a report can be interpreted or construed as insulting, abusive, prejudiced, racist, sexist, ageist or discriminatory in any way.

Social care workers' reports must be anti-oppressive, concise, specific and written in plain English to enable greater understanding by multiple readerships. Report writers must ensure that what they write is not only accurate, objective and correct but that it will be understood by various audiences, such as service users, families, service providers, regulatory bodies and, in some cases, the courts. In this regard, it is important to keep the language simple and reader-friendly.

Active Voice versus Passive Voice

Essentially, there are three main components in a sentence – the subject, the verb and the object. The subject is sometimes called the 'naming part' of the sentence. It identifies the person, group or thing performing the action. The subject is most often a noun, pronoun or noun phrase. The verb, or dynamic verb, denotes the action or doing word. It describes what the subject has done or is doing. The object describes the person, place or thing that receives the action of the verb.

'Active' and 'passive' voice refers to the use of the verb in a sentence. One of the most common mistakes in report writing is using the passive voice, which makes sentences verbose, less concise and less clear.

In the active voice, the action comes before the object. In the passive voice, the object comes before the action. The active voice emphasises the subject, i.e. the person who is performing the action. The passive voice emphasises the object, i.e. the person or thing the action is done to.

Sentence	Active or Passive	Comments
Mary identified a goal.	Active	Subject: Mary Verb: identified Object: goal
A goal was identified by Mary.	Passive	Subject: Mary Verb: identified Object: goal
A goal was identified.	Passive	It is unclear who performed the action of the sentence and therefore affects the accuracy of the report.

The Challenge of Writing Objectively in a Caring Role

Writing objectively in reports means writing about facts, not opinions. Many social care workers find it challenging to write objectively in a caring role. It is good practice to write reports in an impersonal tone and avoid using judgemental, prejudicial or emotional language. Social care workers should also ensure that they are aware of their own perceptions and biases when compiling reports.

As social care workers are motivated by the emotional, relational, interpersonal and social dimensions of their work, it can be challenging to write documentation that disengages these subjective aspects of the social care role in order to prepare an objective account about a particular occurrence. There is also a fear that an objective account of an incident could be misinterpreted. This is a challenge. Even when we all see the same thing we can each interpret it differently.

To ensure objectivity and clarity, it is important to plan the content of a report and to use correct grammar, spelling and punctuation. Unnecessary details should be omitted. The report writer should not offer diagnoses (unless qualified to do so). Inaccurate or misinformed reports can have consequences for the service user in terms of subsequent decision-making and other interventions.

Effective Report Writing

A report can be viewed as a reflection on professional credibility. Therefore, it is imperative that a social care worker writes effective reports and documentation.

When writing a report:

- Organise your thoughts.
- Make sure you know the purpose of the report.
- Lay out the information and determine the format.
- Decide on your writing style.
- Use clear, simple English that is easy to read.
- Keep sentences brief and concise.
- Avoid words that are open to interpretation.

Barriers to effective report writing:

- Lack of understanding of the organisation's policies.
- Being unsure or unclear about what information is relevant or necessary.
- Varying levels of competencies, abilities and expertise among staff.
- Ineffective time management.
- A tick-box culture.
- Rushing to complete reports after a long shift.
- Perception and interpretation.

Reports are necessary for a range of reasons and it can be difficult to ascertain what a good report looks like in all situations (Bogg 2015). However, there are some universal points that a social care worker should apply:

- The purpose of the report is clear.
- The report is written in appropriate language.
- The report is concise.

- The report sets out relevant frameworks and criteria being adhered to.
- The report is proofread to check for any errors.
- The report is signed and dated. (Bogg 2015)

Effective report writing should answer the following:

- Date and time?
- Who was present?
- Where did it occur?
- What happened?
- Did you observe triggers?
- What actions were taken?
- Who conducted the debrief?
- What follow-up, if any, was identified?
- Was the in-house policy referred to?
- Was it necessary to seek advice from line management?

Effective report writing should **never** contain the following:

- Humour or jokes.
- Colloquialisms such as 'lost the plot', 'went berserk', 'had the craic'.
- A diagnosis of the service user – unless you are qualified to make one.
- Discriminatory language.

Useful verbs, terms and phrases:

- It appears
- It seems
- It was decided
- It was recommended
- In particular
- After
- Subsequently
- Consequently
- Although
- Even though
- Displayed
- Became
- Noticed

A Model for Report Writing

Good planning underpins good report writing. You will write a clear, concise and objective report if you take the time to plan what will be in the report and why. It is important that there is a clear sequence of information and the paragraphs are presented in a cohesive and coherent manner with clear links from section to section. The formal nature of report writing for assessments, case reports, access reports, care plans and reflective practices means that reports should be written clearly, concisely, accurately and objectively. Using the GAS (**G**oals and objectives, **A**udience, and **S**tructure and style) model will help you plan the report, record or other document before you begin to write (Bogg 2015).

Goals and Objectives	Audience	Structure and Style
What is the aim of the report? **What are the objectives?** **What is the context of the report?** **What is the report trying to achieve?** **What is the purpose of the report?**	Who will read the report? • Service user? • Colleague? • Line manager? • Supervisor? • Court?	Is there an in-house policy/ template that governs how the report should be written? What are the main headings that need to be addressed? What style will you adopt? Will the report be in plain language?

(Source: Bogg 2015)

Holistic Needs Assessment in the Homelessness Sector

In the homelessness sector, national policies such as the National Quality Standards Framework for Homeless Services in Ireland (2019) provide that a support plan addresses the housing needs of the service user by achieving housing-related goals and considering personal preferences and tenure options. In addition, the holistic needs assessment records the service user's key information, their housing history and needs, family and current relationships, early life and childhood experiences, education, work and job history, legal issues including offending behaviour, income and finance, general physical health, mental health, alcohol use, drug use, independent living skills, equality issues and the service user's own assessment of need. The holistic needs assessment is an important tool that facilitates care planning for people experiencing homelessness that is person-centred and offers the potential to map pathways out of homelessness. The support plan must also detail preferred areas, level of support required and include a risk assessment. In addition, a social care worker in the homelessness sector must prepare daily reports which provide a brief overview of the resident's day, such as appointments attended or a synopsis of key working or significant conversations.

When filling in the holistic assessment form, it is good practice to detail as much information as possible from previous records and to check the accuracy of the information with clients. It is important to become familiar with the information to encourage a fluid conversation. Many of the subject areas are inter-related, such as addiction and the impact on financial resources. Sometimes this can present inconsistent or contradictory information as everyone has different interpretations of life experiences. If this occurs, you may ask for clarification, but if the client is not comfortable talking about a particular aspect, you can move to the next question. The main aim of the holistic assessment is to identify and prioritise areas for action and the supports to enable them. The holistic assessment form may take up to an hour to complete with the client, so it is important to allow sufficient time and to find a quiet location where the confidentiality of the service user is protected and where they feel comfortable and at ease when sharing information with you.

Case Study 1

Alice is a 25-year-old single parent of two children. Alice was in a relationship immediately prior to experiencing homelessness and has reported the cause of her homelessness being experiences of domestic violence, for which she received medical treatment. Alice reports leaving all her possessions in the house and has limited financial resources. This has been very traumatic for Alice and she complains about anxiety, panic and problems sleeping at night. For the past year, she says, she had spent some time with friends, but the living environment was not conducive to rearing two small children. There were experiences of engaging in drink and drug use in the house.

Alice sought help to provide a stable home for her and her children. She came to the attention of homeless services after presenting as homeless to the local authority. She was referred to a regional homeless provider and you have been tasked with completing the holistic needs assessment with Alice.

TASK 1

Apply the GAS Model to this case study of Alice.

Goals and Objectives

- The goal and objective of this report is to provide an objective and factual insight into Alice's situation.
- The holistic needs assessment also sets out the strengths, needs and risks in Alice's life.

Audience

- The report is person-centred and therefore Alice will be contributing and reading its contents.
- Your line manager may read the report.

Structure and Style

- The holistic needs assessment will be available in template form and you will need to provide a clear, concise, accurate and objective report based on the information provided to you by Alice.
- The main topics are outlined in the template.
- The assessment also provides an opportunity for Alice to identify her own assessment of needs.
- This report should be written in a formal style.

Tips for Practice Educators

This proficiency will enable students to produce clear, concise, accurate and objective documentation.

- It is important that sufficient time is afforded to the student to develop this proficiency.
- It is also important for practice educators to provide constructive feedback to students and facilitate regular debriefings for students in an enhanced collective learning environment. Examples of best practice in report writing would supplement the learning experience of students in developing this proficiency.
- Students should be equipped with the knowledge and skills of how to produce quality and effective reports.
- Students should be given the opportunity to practise report writing and reflect on any aspects of their work that could be improved for future tasks.
- Practice educators should ensure that students receive both task-based learning and one-to-one tuition where the need arises.
- Relating theory to practice with exemplification is a cornerstone of learning for students. The 360-degree performance appraisal might be a useful theoretical framework for practice educators to provide constructive feedback to students on developing their proficiency in producing clear, concise, accurate and objective documentation.

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Chapter 30 – Ailish Jameson

Domain 2 Standard of Proficiency 7

Be able to apply digital literacy skills and communication technologies appropriate to the profession.

KEY TERMS

- Digital literacy
- Homeless services: pass system
- Alternative and augmentative communication
- Technology to promote independent living
- Technology for those who experience communication difficulties
- COVID-19 and communication technologies

Social Care means connection at a human level with those who are vulnerable and often marginalised by society. Social care involves using a diverse range of skills to support, safeguard and empower service users to improve and enhance their quality of life. It involves compassion, empathy, critical analysis, communication, relationship building, assessment and intervention, all centred around the holistic needs and the strengths of the person. Social care incorporates the principles of social justice and advocacy, being the voice for those who are disadvantaged by the inequalities in society and, most importantly, working with service users to empower them to use their own voices to address injustice

TASK 1

Reflect on how you use digital literacy skills to complete your work as a social care worker. What are the advantages and disadvantages of digital technologies and digital literacy skills?

Digital Literacy

At the core of all social care work is the ability to build and maintain relationships. One of the key skills in relationship-building is communication. Over the past number of decades the way in which we communicate has evolved and changed from primarily paper-based methods to online and the increased use of information technology. Information and communication technologies (ICT) are used both in how we deliver social care services and our routine day-to-day interactions with service users. We are required to be digitally literate, but what does this mean? How can we utilise ICT to improve our systems of care provision and the experiences of those accessing social care services? This chapter will examine digital literacy and communication technologies and how they work to promote and enhance communication in social care. It will discuss different systems of social care provision, systems in use in the homeless sector, use of technology in intellectual disability and autism services and with respect to children and young people in care.

According to the American Library Association, digital literacy is the ability to use information and communication technologies to find, evaluate, create, and communicate information, requiring both cognitive and technical skills. Digital literacy and technology has led to significant changes in how social care work is delivered and the interactions with service users in our care. In 2016, the UK's Local Government Association published a report entitled 'Transforming Social Care through the Use of Information and Technology', which highlighted the important role of information and technology in the delivery of social care services. Among other improvements, the report held that digital literacy and technology has resulted in the integration of services and information for children, families and adults, has led to improved interactions with care services and promoted independence and wellbeing. In Cumbria, for example, an electronic referrals and matching system called Strata has been implemented across all adult and children's services, resulting in over 1,000 referrals a month. It has enabled organisations to automatically make referrals to social care organisations and has resulted in reduced form-filling and significantly cut the time needed to make a referral (LGA 2016).

TASK 2

Read the Local Government Association (UK) (2016) report 'Transforming Social Care through the Use of Information and Technology'. Examine the five key themes (pages 6-16) for improving services through the use of digital literacy and technology. How might you incorporate some of the ideas into your workplace to improve the communication process?

Download the report from www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/informatics/transforming-care-through-technology

Homeless Services: Pathway Accommodation and Support System (PASS)

Case Study 1

Joe (pseudonym) is an 18-year-old boy who has recently become homeless. Joe was spotted on the streets by Gardaí and brought to the station. Joe informed the guards that he could not return home due to current living conditions and poor relationships there. The Gardaí have contacted your service enquiring about bed availability for Joe.

What is important here is that Joe feels secure and that his needs will be met. Through the use of a centralised database system, communication between the different homeless services is streamlined and homeless agencies can access information on bed availability and service providers who can ensure Joe achieves a placement.

PASS is a shared online system used by every homeless service provider and all local authorities in Ireland. This system enables the four Dublin local authorities, the Health Service Executive (HSE) and all homeless services to communicate through one unified system and provide an integrated system of service provision and effective case management to those who are experiencing homelessness. The PASS system provides 'real-time' information on numbers presenting as homeless as well as bed occupancy, ensuring the most up-to-date statistics on homeless figures.

However, this shared system also uses the information shared on the system to improve service delivery and monitor, co-ordinate and plan the delivery of services (DRHE 2020). For example, agencies working with people who are homeless can record and share the work they conduct with clients. This means that resources are utilised more effectively, there is less duplication of work and a continuum of care is provided to those accessing homeless services, resulting in an integrated delivery of care. Through monitoring the delivery of services, individual organisations can track outcomes of the work conducted with clients, compare with other providers and evaluate the effectiveness of services. The PASS system enables services to be co-ordinated more effectively through information sharing and targeted interventions. Through having one unified system for homeless services, planning and development of services can be more seamless as information can provide important data on the homeless population profile, any emerging trends in the sector and detail on how services are being utilised.

Alternative and Augmentative Communication

As social care workers, we often encounter service users who have difficulty communicating verbally. In recent years, augmentative and alternative communication have become the norm in social care services in order to assist service users to have a voice and communicate their needs. For some service users, speech may be limited, so many devices have been introduced to improve (or augment) their speech. Other service users may not have any speech, and many devices can be used as an alternative to speech, thus ensuring that service users are autonomic and are heard in relation to their care. Some of these devices are explained below: the list is not exhaustive.

Technology to Promote Independent Living

One key aim of social care work is to promote independent living and afford greater choice to service users in their own lives. Through the use of digital technologies, an increased number of service users have been supported to live independently in their own home (LGA 2016). This brings reassurance to carers and families, who may not always live locally to those they are supporting. The 'traditional' method of service delivery is changing, however, with a greater emphasis now on how technology can support people through proactive alert monitoring rather than reactive response calls. In order to facilitate independent living, discreet monitoring devices have been installed in care homes, sheltered housing or privately owned homes to support passive remote monitoring (LGA 2016).

Just Checking

One example is the Just Checking initiative introduced in Liverpool which reduces the requirement to provide 'sleep-in' support to service users in supported accommodation, affording the individual an increased sense of independence as well as reassurance for family members and other carers via wellbeing electronic notices (Just Checking website). It has been found to be very effective for those with learning disabilities and/or autism. Key to this technology is the idea of supported living, so the technology is not a replacement for the workers, but it augments the support given to the service user in order to promote safe independent living.

Just Checking works by means of movement and door sensors which are placed around a property, on walls and skirting boards. These sensors create a chart of activity; for example, sensors show when a door has been used and how long it has been open. It can track when an individual enters or leaves a property and how long they have been out. A Plug and Go Hub is plugged in and information from the sensors go to the hub. Support workers can log into the Just Checking hub to view the activity charts, add new users and set up notifications on any smart device with an internet connection.

See Greg's story: https://vimeo.com/173928293

Just Roaming

Just Roaming is a real-time system for people in supported living. Again it is used to augment rather than replace the role of the social care worker. It is a flexible, responsive overnight support system which uses sensors to send live alerts to a mobile phone. If an alert is received, a roaming support worker responds. Alerts are personalised to the needs of the individual, so that the right support is provided at the right time. This could be reassurance and guidance for someone who has been to the bathroom, is now in the kitchen and has not returned to bed, or immediate attention if, for example, someone is having a seizure. Just Roaming is proving more personalised and timely than sleep-in support, and has transformed the independence, choice and control of those who are being supported.

Technology for those who Experience Communication Difficulties

Talking Mats

Talking Mats are a visual framework to help people express their views using a selection of communication symbols that cover a variety of topics and are used in a wide range of health and social care settings. They are available in an original low-tech and digital resource. At the core of our work is person-centred care and, most important, the inclusion and participation of service users in every aspect of their lives. Talking Mats assist service users in their decision-making process in relation to the care planning process and faciliate meaningful participation in setting personal goals with respect to education, health and social care plans. In children's services, transitions form a large part of a child's life and Talking Mats have been found to assist in the preparation for transitions and investigating sensitive or difficult issues. See a video on Talking Mats on https://www.youtube.com/watch?v=SzAgGmLYpE0#action=share

Communication with Children and Young People: Emotions

For many young people, and particularly those in the care system, communicating emotions can be very challenging. Many young people in the care system have experienced a great deal of trauma in their lives, which can often be internalised and lead to difficulties in communicating feelings and emotions (Buckley *et al.* 2016). This can impact on relationship builiding with key workers and the social care team. As social care workers we need to be creative in how we reach these young people and facilitate expression of emotions in a safe and trusted environment. Using technology is ingrained in young people's lives, so it is important that we as social care workers meet young people where they are at in terms of their communication. The traditional means of communication across a table simply does not fit in with how young people communicate today. One organisation, Mind of My Own in the UK, has designed many apps to assist in the process of communcation for young people in the care system. One form of information and communication technology used with young people is apps.

Apps and Young People

Apps are providing new ways for young people to stay in touch. Mind of My Own (MOMO) makes it easier for children and young people to communicate with their care team and make more frequent and coherent contributions to their reviews, conferences and other care-related meetings. For an explanation on how it works see https://vimeo.com/322192496 and for how it is used go to https://www.youtube.com/watch?v=Qqqla0rRtH0

It has promoted active participation by children in the delivery of services provided to them, and has been preferred to previous methods of engagement by a significant proportion of young people.

Smiling Mind

Smiling Mind is a free app for young people which helps build an understanding of mindfulness and meditation. One key aim of social care work is to build resilience and wellbeing in young people, and mindfulness and meditation have been found to help them build confidence and calm. This app can help young people become calm, be clear about their emotions and feelings and be more contented in their lives. If introduced at a younger age, this can assist with stress management and help mitigate mental health risks and issues in later life. The app includes reminders for users to complete different daily activities and could easily be used in social care organisations with children and young people. It can be downloaded from the app store or Google Play. See https://www.smilingmind.com.au/ for further information and for free download.

See also https://www.teachthought.com/technology/5-ipad-apps-for-social-and-emotional-learning/ for details of other apps for building social and emotional learning in children and young people, which range from $0.99 to $3.99 to download.

COVID-19 and Communication Technologies

The COVID-19 pandemic has presented significant challenges for the delivery of social care services across all sectors. The lockdown in March 2020 resulted in many day services being closed and links with service providers being curtailed for service users. The need for social distancing in order to reduce the transmission of the virus has resulted in an increased use of information and communication technologies in the sector. Many have enabled virtual appointments and key working sessions to take place, providing some degree of continuity of service for service users. The following are some of the platforms being used to deliver virtual support and services. Staff should ensure that any of the platforms being used are approved by the service providers and in line with the organisation's IT policies and standards. In addition, platforms being used should met data protection legislation.

MS Teams

MS Teams provides a platform for video and audio conferencing. If the service has a business account, staff will be able to schedule meetings with service users and use other features, such as recording or using channels if small groups are required. It contains a scheduling assistant which assists with organising meetings, with an automatic link being generated and sent to the recipient. It also has a chat facility. For service users, the MS Teams app is free to download and they simply click 'Join Now' to enter a meeting room once the invitation has been set up. It is free to set up a personal account on MS Teams, but some of the advanced features are not activated but are being constantly updated by Microsoft. MS Teams enables users to share content such as presentations or documentation, so it is collaborative in nature. This might be particularly useful in care planning reviews or multi-agency meetings. Follow this link for a short tutorial on how to use MS Teams: https://www.youtube.com/watch?v=jugBQqE_2sM.

Skype for Business Basic

Skype for Business Basic is free to download and offers users instant messaging, audio and video calls and online meetings. A charge applies for more advanced features. It differs from MS Teams in that it was primarily set up to support video calls and video conferencing, whereas MS Teams is a more collaborative platform.

WhatsApp

WhatsApp is a free download primarily used for messaging, but it also supports audio and video calls. It is particularly popular with young people as it is easy to use and calls and texts are free.

Zoom

Zoom offers a video conferencing, web conferencing and webinar facility. A basic plan is available for free which offers unlimited meetings; however, there is a time limit of 40 minutes. When a meeting has been set up a Meeting User ID is generated and a password is forwarded to recipients. They click on the link to the meeting and are prompted to enter the ID and password to gain access to the virtual room. The host must admit attendees to the meeting area.

Tips for Practice Educators

An important element in ensuring that a student achieves this proficiency is for practice educators to alleviate any anxiety felt by students with respect to using information and communication technologies during their placement. First, if a centralised database is used in the service for updating service user engagement and attendance, training could be given to the student on arrival on placement. As part of their duties, students, if permitted under data protection and GDPR legislation, could be permitted to enter and update records in order to develop competence in this technology.

As a key element of social care work is building and maintaining relationships with service users, the ability to communicate is an essential skill for all students to develop while on practice placement. Depending on the service user group, the communication needs may differ. It is important that students learn and use the technology to communicate effectively with service users. So, for example, a service user with autism may use a tablet to communicate their activities of daily living, their preferences and wishes. If students are allowed access to a tablet and given guidance on the meaning of the different signs and symbols, they will very quickly understand the needs and wants being expressed by a service user. This will help create a bond between the student and the service user and may alleviate any challenging behaviour that may occur if a service user's needs are not been met. This should be regularly reviewed at supervision sessions to ensure that the student is being given the opportunity to learn the technology required for communicating with service users in the service.

Similarly, it would be useful for students who are placed in children's residential centres to learn about the technology used for expression of emotions, for example. This would, of course, need to be supervised and managed as it could potentially be a very sensitive areas for service users. It may be the case that the keyworker should demonstrate to the student how apps are used with young people who have difficulties in communicating, particularly around emotions. This will demonstrate to the student that there are different ways to communicate than the traditional means of sitting down at a meeting table with a young person, asking questions and taking notes. The use of technology in expressing emotions is often an important first step for young people in care to identify their feelings. It can be a safe means and a starting point for subsequent in-person meetings about emotions and feelings. Again, allowing students access to technology such as apps and allowing them to observe them in action will help them be confident in using them and in incorporating them into their work with service users and enable them to build strong connections. Students can build on this work with service users and provide a safe place to meet and discuss issues and challenges.

COVID-19 has changed how many social care organisations work, and they have moved to a more virtual space. Digital literacy and information technologies are core to communication, not solely with service users but also with staff. As far as possible, students should be given opportunities to utilise the different platforms for communication. Allowing students to attend virtual staff meetings would greatly facilitate their learning in many areas such as teamwork, task delegation, multi-agency working and inter-disciplinary work. Of course, it is important that students understand policies on IT usage and using technology in accordance with data protection and GDPR legislation. Asking a student to create and host a meeting with a service user and with an external agency would be of huge benefit in terms of meeting this proficiency. Having an understanding of databases and their use for cross-communication between different agencies would also be of use to students in terms of e-referrals and occupancy rates.

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Chapter 31 – Garreth McCarthy

Domain 2 Standard of Proficiency 8

Be aware of and comply with local/national documentation standards including, for example, terminology, signature requirements.

KEY TERMS

National documentation standards

Local documentation standards

Terminology

Signature requirements

Social care is … about meeting people at a particular stage in their lives and supporting them overcome their challenges and assist them with reaching their goals.

TASK 1

Describe one relevant National Quality Standard Framework and discuss how this policy relates to a particular care setting. (Think of your last placement or previous social care position.)

Introduction

Social care workers in Ireland work with a diverse range of service user groups and/or individuals. They are therefore required to have an awareness and understanding of a variety of national standards. This chapter will focus on the National Quality Standards Framework (NQSF) that was devised for homeless services in Ireland. The themes and standards in the National Quality Standards Framework were predominantly adapted from those used by the Health, Information and Quality Authority (HIQA).The relevance of the HIQA standards in relation to homeless services will also be briefly discussed. There are many families with dependent children currently experiencing homelessness, so the 2017 Children First Guidelines will also be discussed; social care workers working with children have a statutory responsibility to comply with the guidelines. Challenges that social care workers experience when adhering to both the national standards and guidelines will be highlighted.

National documentation standards

The aim of the NQSF is to ensure that services that support individuals experiencing homelessness are well organised and are of a high standard. It also aims to accomplish appropriate co-ordination and integration between services, to ensure that services and practitioners are focused on supporting individuals and families to secure suitable long-term accommodation in a timely manner (within six months) (DRHE 2019).

Section 10 permits local authorities to allocate funding to NGOs and private agencies to deliver and manage emergency and long-term accommodation for individuals/families experiencing homelessness on behalf of the government.

Interpreters contribute to assessment and intervention processes by facilitating communication, and by doing so, they gain insight into service users' experiences, perspectives, wishes and feelings. Discrimination and oppression are common experiences for emergent bilinguals, thus facilitating communication is an anti-racist and anti-oppressive practice issue. Ensuring that services are provided in a suitable format and facilitating communication is helpful in recognising people's language, history, culture, traditions and religion (Keating 2000). Using an interpreter when language is an issue is important to ensure understanding and gain clarity. This is particularly important when completing risk assessments, informing service users of their rights, in child protection issues, for consent to engage in services or share information to other services, and in line with General Data Protection Regulations (GDPR).

Homelessness has become a major social concern in Irish society, with both adults and children living in emergency accommodation (Hearne 2020). In 2015, the Dublin Region Homeless Executive (DRHE) devised and introduced the National Quality Standards Framework. The standards were developed in collaboration with other stakeholders, such as non-government organisations (NGOs), Tusla (the Child and Family Agency), HIQA, the Health Service Executive (HSE) and service users themselves. All statutory, NGO and private providers that receive funding under Section 10 of the Housing (Miscellaneous Provisions) Act 2009 must abide by the standards set out.

To address the overwhelming number of families entering homelessness, emergency accommodation (Family Hubs) was introduced in 2016 (O'Sullivan 2020). The NQSF was updated in 2018 to include family homeless accommodation. There is an inspection team who conduct inspections in each homeless service funded by the DRHE to ensure that organisations are adhering to the standards. There are currently 26 standards under eight themes. These are outlined on the DRHE's website (www.homelessdublin.ie/content/files/NQSF-Standards.pdf).

The terminology used in the NQSF is similar to that in the regulatory framework devised by HIQA. See HIQA's website (www.hiqa.ie/sites/default/files/2018-11/national-standards-for-childrens-residential-centres.pdf).

Health Information and Quality Authority

HIQA is the sovereign authority accountable for ensuring safety, quality and accountability in social care and health settings. It is responsible for ensuring that children's residential, child protection and fostering services are compliant with the standards and conducts frequent inspections (HIQA 2018). Although HIQA carries out inspections in residential homeless services for the under 18s, it is important to note that as of 2020 HIQA does not conduct inspections on family homeless emergency accommodation. The DRHE's own inspection team is tasked with conducting assessments of family homeless services.

Family homelessness is complex

Families enter homelessness for a variety of reasons, including parental substance misuse, mental health problems, loss of employment, domestic violence and breakdowns in family relationships (Walsh & Harvey 2015). The role of the social care worker is to support family members with identifying specific needs for which they may need support and ensuring that appropriate services are provided to meet such needs. When working with families in homeless accommodation, the priority of the service is to support them to find suitable accommodation, while also ensuring that their individual needs are met. Building relationships enables the social care worker to develop trust with the service users and support them to meet those needs. Lishman *et al.* (2018) assert that creating positive relationships through displaying empathy and unconditional positive regard towards service users is an integral part of social care work.

Children First 2017 Guidelines

Tusla (2015) emphasise that each organisation and practitioner involved in homeless emergency accommodation has a statutory obligation to comply with the 2017 Children First Guidelines (Children First Act 2015). The economic crash in 2008 resulted in high unemployment, and over-reliance on the private housing market has caused family homelessness to soar in recent years (Kenna *et al.* 2018). In September 2020 there were 1,128 families with 2,583 dependent children residing in emergency homeless accommodation throughout Ireland (DHLGH 2020). The high number of children experiencing homelessness creates additional challenges for social care workers.

Children are at risk of many forms of abuse or neglect, and they can also experience bullying in social environments from other individuals or groups. Ensuring the safety of children is paramount, although it is essential for practitioners to strike a balance between safeguarding children and respecting the needs and rights of the parents and the family (DCYA 2017). There are many children from different backgrounds, nationalities and cultures living in homeless accommodation together. The Ombudsman for Children's Office (2019) reported that living in communal areas in close proximity within family hubs caused tension among children, which led to numerous children experiencing bullying. One approach used by social care workers to address bullying in a family hub was to deliver a bullying education programme.

If a child is experiencing abuse or neglect it is imperative for practitioners to be aware it may not be intentional. The parent/carer may be struggling to cope themselves (Harris & White 2018).

This can be evident in family hubs – parents are experiencing emotional distress, which can lead to them feeling frustrated and becoming temperamental towards their children (Brand & Ciccomascolo 2020). When residing in family hubs, social care workers must ensure that children are safeguarded from any abuse or neglect, while also providing emotional support for the parents/carers.

Having to adhere to both the National Quality Standards and the 2017 Children First Guidelines can create challenges for practitioners. Completing documentations such as incident reports, risk assessments, observation logs and handovers increases the administrative workload for social care workers. Means *et al.* (2008) note that bureaucracy inhibits social care workers from engaging in direct practice. The NQSF places a strong emphasis on applying a person-centred approach. Each organisation and practitioner must ensure the service user is supported with developing their own independence and afforded the choice to make their own decisions. The 2017 Children First Guidelines state that it is essential that children's safety is paramount and that all practitioners must report any concerns regarding the child's welfare to Tusla. The NQSF was established to assist organisations and practitioners to ensure high-quality standards in the provision of services (Ombudsman for Children's Office 2017); and Biesel *et al.* (2020) emphasise that the main objective

of the Children First Guidelines is to protect the welfare of the child. Social care workers must ensure that the Children First Guidelines take precedence over any other framework. The following case study outlines a challenging situation typical of the kind that staff working in Family Hubs encounter.

Case Study 1

Jane is a single mother (34) who is living in a Family Hub. She has two children aged 10 and 16. Jane does shift work, which involves doing some night shifts, and she is not in a position to have someone mind her children while she's working. On occasions, the staff team have noticed, she leaves the 16-year-old to mind his sibling while she is in work. The policy of the service states that children must be supervised at all times, and that if children are not supervised a report must be sent to Tusla.

Jane's key worker discussed their concerns with her and Jane said that she is struggling to find people who can support her with minding the children. Jane is aware of the policy and procedure and told her key worker that she needs the job to be able to provide for her children; and the job is helping her to retain some normality in her life with the current situation she's in.

Her key worker was unsure of the right course of action to take.

TASK 2

What action would you take if you were faced with this situation?

Refer to:

Tusla report forms (www.tusla.ie/children-first/publications-and-forms/)

Children First National Guidelines (2017) (www.tusla.ie/uploads/content/Children_First_National_Guidance_2017)

Jane's key worker brought the issue to management and was informed that a report had to be sent to Tusla in line with Children First Guidelines. Her key worker highlighted the National Quality Standards and said that the team needed to support Jane to maintain her own independence. A decision was made that the children could stay in the service with staff supervision until 10 p.m. Jane would have to be in the service at that time to ensure she is supervising her children.

The decision caused Jane to lose trust in the team as she felt her parenting ability was being undermined. It also limited the number of shifts Jane could do, which created a financial burden on the family. The positive relationship between Jane and her key worker allowed for them to discuss the situation and Jane acknowledged the gravity of the situation and appreciated the flexibility the team had provided to try support her. Jane complied with the agreement and no additional reports or further action needed to be taken. Jane was supported with securing suitable accommodation for her and the children and moved out within the next two months.

Local Documentation Standards: Holistic Needs Assessment

Organisations and practitioners working with individuals who live in emergency homeless services are provided with Housing Needs Assessment (HNA) books. The forms provide clear advice regarding the services user's rights to give consent in relation to their information being shared. If the service user does not give or wishes to withdraw their consent, practitioners would not have the legal right to discuss any information regarding the service user. The HNA permits the service user and practitioner to develop a person-centred care plan and identify a plan to secure suitable independent accommodation. The HNA also enables the service user and practitioner to identify any additional needs for which the service user may need supports. The HNA assessment is a voluntary system and service users are given the choice of whether they wish to engage in the process. The system was introduced to ensure that service users and staff are not having to continuously engage in initial assessments. The focus is to encourage consistency within the service user's assessment and care plan and enhance the sharing of information between organisations (DRHE 2017).

> Two social care workers – Eoin, working in a homeless residential service; and David, in a community addiction service – emphasise the importance of relationship-building and communication:
>
> 'The HNA and the Initial and Comprehensive Assessment systems are similar in design; both take a holistic approach. Both books are appropriate tools to assist the social care worker and service user with identifying specific needs and developing suitable care plans.' Care Plans may need to be adapted or a new one devised if additional needs arise. The establishment of a good relationship between the social care worker and the service user enables honest discussion on such issues. Building a good rapport with other services will place social care workers in a good position to develop good communication between other practitioners, which prevents duplication and repetition of the work and ensures the right actions are taken to support the service user's needs.'

A majority of people experiencing homelessness have many and complex needs. No one service has the capacity to support individuals to meet all their needs. Homeless residential services are limited in their facilities, which prevents them from being able to deliver appropriate supports to individuals who want to overcome addiction our mental health issues (O'Sullivan 2008). When engaged in the HNA system while residing in homeless accommodation the service user, with support from the practitioner, may identify specific needs in relation to addiction issues. To ensure the service user gets the appropriate support needed to overcome their addiction the practitioner would need to refer the service user to either a community or residential addiction service, whichever is deemed appropriate.

Initial and Comprehensive Assessment Book System

In 2014, an Initial and Comprehensive Assessment Book system was developed to support addiction services and practitioners to conduct initial and comprehensive assessments (Kirby 2014). The 2017-2025 National Alcohol and Drug Strategy suggests community and residential addiction services use this system as an appropriate tool to assist with identifying suitable supports to assist and address complex needs (DoH 2017).

The book is designed with questions which are devised under specific themes including substance use, accommodation, medical, financial, treatment history, education/employment, legal and relationships. The concerns identified may change either positively or negatively and additional issues may arise. The role of the practitioner is to have an understanding and awareness of each need that was initially identified, and compare and contrast these with the service user's current status.

Establishing specific needs ensures an appropriate care plan is devised to assist the service users with accessing the right supports. Displaying empathy and transparency towards the service user assists with building a trusting relationship. This will help the service user to feel comfortable and encourage them to disclose the precise nature of their current circumstances. Establishing a positive relationship supports the development of an effective care plan.

An example of the Initial and Comprehensive Assessment Book can be found at: www.corkdrugandalcohol.ie/wp-content/uploads/2015/04/Case-management-manual-2014.pdf.

Engaging in both the HNA and Initial and Comprehensive Assessments Care Plan systems supports social care workers and service users with identifying specific needs, which assists with devising appropriate support plans. Good communication and collaboration between all parties involved in the service user's care plan can lead to productive outcomes for the individual.

Example

When engaging in an initial assessment the service user may not feel comfortable revealing the exact extend of their substance use. The service user may say they are engaged in a methadone programme and adhering to the prescribed dose and that their goal is to seek detox residential treatment. The care plan would be developed with the aim of making a referral to a residential detox unit and providing therapeutic supports while they are waiting to access the residential service. However, while engaged in a comprehensive assessment, which happens over time, the service user may disclose that they are also using additional substances such as benzodiazepine and cocaine. This would mean that the care plan would need to be revised and the goal may change to suggesting the service user attend a residential or community stabilisation programme.

'An individual who resided in our service was supported with accessing supports regarding his addiction and is now entirely abstinent from all substances and secured his own accommodation with our supports. His positive journey is inspiring.' (Tracey, a social care worker in a residential homeless service)

Terminology Used

When discussing individuals, the terminology we have used throughout this chapter is 'service user'. Martin (2010) asserts that the phrase 'service user' has for many years been the most common term in social care literature and practice settings. But it is not the preferred term in all services. Because different terms are used to describe service users in different social care settings, the language used in documents and reports is not always consistent. Homeless residential services refer to individuals as residents. Residential addiction services are primarily staffed by the medical and therapeutic professions, which means that the individuals are known as clients. Community addiction treatment (day programmes) may categorise individuals as clients or participants. As a social care worker, it is important to be fully aware of the terminology used both in the field in which you work and other fields which you engage with. Social care workers liaise with multiple agencies and professionals, which involves a diverse range of correspondence in relation to care plans, reports and referrals. Knowing and complying with the terminology used is part of being a competent professional.

Signature Requirements

In 2018, the Irish Data Protection Act was devised following the introduction of the 2018 European General Data Protection Regulations. Under the Act, all organisations, agencies and practitioners must ensure that they receive written consent from each individual who engages with their service. The individual's right to confidentiality is at the forefront of both the HNA and Initial and Comprehensive Assessment systems. It is imperative when requesting consent that the service user is aware and fully informed of the reason why they are being asked to give their consent. As a social care worker it is important to note, as highlighted by Morley *et al.* (2014), that service users must be informed that their confidentiality cannot be assured if there is a disclosure of potential risk of harm to the service user or to others.

Ireland has become a multicultural society, which has led to many nationalities from different ethnicities experiencing homelessness (IHREC 2019). There can be language barriers, creating difficulties for non-Irish national service users and social care workers when seeking consent (O'Connor & Ciribuco 2017). Having a professional translator present would ensure adequate communication between both parties. Since this is not always possible, another tool used by social care workers is a translation device on their mobile phone. In addition, the HSE (2013) emphasises that service users may have limited literacy skills and difficulties with communicating, so it is important to give individuals time before they give their written consent. If the service user finds it problematic to provide written consent, having them place a mark (e.g. 'X') on the document to indicate consent would be sufficient.

Some useful information on this subject includes:

- *Migrant Integration Strategy 2017-2020* (DoJ 2019)
- *Guide to the General Data Protection Regulations* (ICO 2018)
- *National Consent Policy* (HSE 2013)
- *GDPR Consent* (Intersoft Consulting website)

Some individuals who experience homelessness and/or substance misuse would have experienced mistrust, which makes them more cautious about signing any type of document. The service user could refuse their consent for the social care worker to contact specific others, as it is their legal right to do so. This can create challenges, because if consent forms are not signed the social care worker would not be in a position to discuss the service user's case with other professionals. This in turn would prevent the social care worker from gathering or relaying relevant information needed to implement appropriate supports outlined in the care plan. This is another reason why it is so important for the social care worker to form a good positive relationship with the service user. Riggall (2012) emphasises that this is the first requirement for a practitioner when working with a service user. A positive working relationship encourages trust to develop between the two parties. It is imperative to reassure the service user that any information relayed to others is to support them to achieve their goals. You can learn more about how to develop a positive working relationship in Chapters 35, 36, 38 and 39.

Tips for Practice Educators

The basis for this proficiency is for the student to acquire an awareness of the national and local documents that outline the standards that practitioners must adhere to in social care settings. The proficiency places an emphasis on the ability to understand the requirements needed in relation to obtaining the service user's signature, and the differences in the terminology used in specific social care settings (particularly documentation). Identifying, outlining and discussing the different national and local documents would assist the student to develop an understanding and awareness on what is required of them when on placement or working in the relevant fields.

Having the student's complete case studies would help them develop an awareness and knowledge of national and local standards documentation and an understanding of the documents used to conduct assessments. This would encourage confidence and prepare them to be in a position to be able to apply their learning in practice.

Throughout their studies students will encounter a multitude of literature and textbooks that use the phrase 'service user' when discussing individuals availing of social supports. This terminology may create challenges for students as this term is seldom if ever used in the work setting. As highlighted in this chapter, there are a variety of terminologies used in different social care sectors. Identifying and discussing the various terms used in specific sectors would enable the student to be self-confident when undertaking their placement practice.

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Chapter 32 – Maeve Dempsey and Collie Patton

Domain 2 Standard of Proficiency 9

Be able to express professional, informed and considered opinions to service users, health professionals and others, e.g. carers, relatives, in varied practice settings and contexts and within the boundaries of confidentiality.

KEY TERMS

- Professional boundaries
- Communicating informed opinion
- Professional and ethical communication
- Boundaries of confidentiality
- Davidson's Professional Relationship Continuum

Social care is … a relationship-based practice characterised by the dynamic and complex needs of vulnerable individuals within society. The role of the social care worker is to support and respond in a manner informed by knowledge and best practice, tailored to the individual's identified needs, while being aligned to ethics, standards and engaged in accountable and reflective practice that is both respectful and boundaried towards the individual. By its very nature, care and support permeates social care relationships, which have the capacity to become a pathway and catalyst towards positive change.

There are four other relevant proficiencies in the Standards of Proficiency for Social Care Workers (SCWRB 2017), outlined in the table below. This chapter focuses explicitly on the boundaries of confidentiality.

Domain	Chapter in this book	Focus on the Relationship
D1 SOP10 **(2017: 4)**	CH 10 by Anthony Corcoran	*Understand and respect the confidentiality of service users*
D1 SOP11 **(2017: 4)**	CH 11 by Noelle Reilly	*Understand confidentiality in the context of the team setting*
D1 SOP12 **(2017: 4)**	CH12 by Maria Ronan	*Understand and be able to apply the limits of the concept of confidentiality*
D1 SOP14 **(2017: 4)**	CH14 by Teresa Brown and Margaret Fingleton	*recognise and manage the potential conflict that can arise between confidentiality and whistle-blowing*

TASK 1

Please read Chapters 10, 11, 12 and 14 and answer the following questions: What is confidentiality? From your experience, are there limitations or situational contexts associated with confidentiality?

Defining Boundaries

Boundaries are *'the limits that allow for a safe connection based on the client's needs'* (Peterson 1992: 74) and are also the limits we set in relationships that allow us to protect ourselves. Through self-awareness, we develop clarity and insight into what is acceptable and unacceptable to us as individuals in terms of our boundaries, both personally and professionally. The concern about appropriate boundaries is, at least in part, a concern about the effects of the power differential between client and professional, recognising that we are working at a deep level with vulnerable individuals and thus there is a risk of boundary violations (Dietz & Thompson 2004). It is our responsibility to ensure that the support and care we provide to vulnerable individuals does not further disenfranchise or disempower them.

From a self-care perspective, social care work can be challenging and practitioners are frequently exposed to highly stressful and emotive situations. Consequently, maintaining strong and clear professional boundaries allows us to manage ourselves and regulate our emotions to ensure we are operating in a safe and ethical manner, cognisant of the limitations and boundaries of our role.

Professional Boundaries in Social Care

The relationship between social care practitioner and client is the central component in meaningful and effective social care work. How this relationship develops and functions is of significance when understanding the importance of boundaries and the limitations of confidentiality. In many ways, this relationship is born from an imposed and artificial situation and is characterised by a distinct imbalance of powers. This is inevitable because the worker's role, influence, authority and access to confidential and sensitive information pertaining to the client and the client's needs guide the relationship. The journey for both social care worker and client towards developing this relationship to a therapeutic one requires trust, effective communication, empathy and unconditional positive regard on the part of the social care worker. It also requires time and commitment. During this process, like any relationship, there is a 'getting to know you' stage which involves sharing information, often personal and significant to the client. It is at this stage that the foundations of clear and professional boundaries are laid, and the onus to both establish and maintain those boundaries must fall to the social care worker. This is not always an easy task and, in recognition of the dynamic and complex lives of clients, social care workers are often faced with ethical grey areas that challenge their professional boundaries and can result in lines being crossed. The context, the needs of the individual, the role of the social care worker, and the potential for misinterpretation are significant factors in understanding what constitutes balanced and boundaried practice.

TASK 2

Think about: Where do we draw the boundary between personal and professional relationships? How should social care workers present themselves to service users?

Davidson's Professional Relationship Boundaries Continuum

The professional relationship boundaries continuum

A useful model for understanding and exploring appropriate professional boundaries is Davidson's (2004) professional relationship boundaries continuum, a conceptual framework that encourages social care workers to engage critically with the complex relationships that exist with clients, between professionals, and subsequently identify boundary violations, increase self-awareness and critical reflective practice and initiate prevention strategies. Davidson (2004) provides both a point of reference and a common language for discussing the actions, choices and processes related to the boundaries of human service providers' professional relationships.

According to Davidson (2009: np), *'an individual who has an authentic and caring manner while maintaining clear boundaries is demonstrating balanced boundaries … They actively use professional judgment, consistently apply self-reflection skills, and are intentionally accountable to other professionals … Professionals with entangled professional boundaries are consistently over-involved in the lives of the clients they serve. They invest more of their time, emotional energy or favour in these relationships than in others, and they meet their own emotional, social, or physical needs through the relationship at the client's expense.'*

The significance of this framework as a 'continuum' acknowledges movement, progression and stages that are not clearly delineated. Therefore we can conclude that our boundaries have the capacity to change, are not concrete and can both progress and regress. In order to prevent regression to entangled boundary violations or rigidity in approach, and to ensure social care workers are practising with balanced boundaries, the topic of boundaries needs to be consistently on the agenda in team meetings and in supervision and should feature consistently within our own reflective practice. Research reflects that the more honest and open the communication between practitioners, the less likely it is that clients' boundaries will be crossed (Thompson *et al.* 1995).

TASK 3

Using the Davidson professional relationship boundaries continuum (2004), describe and reflect on a recent experience in which you felt your professional boundaries were challenged. What insights and awareness have you in relation to what influences or impacts your boundaries?

Ethical and Professional Communication

The concept of relationship-based practice (RBP) has, at its core, the centrality of relationships and reciprocity in professional helping relationships (Mulkeen 2020). Acknowledging that the therapeutic relationship is at the core of social care practice, it would make sense that communication, an ability to express oneself appropriately and succinctly as a professional, is key to developing relationships between practitioner and client, and their families, but also between practitioners and other professionals. Language is a medium for communication, whether through words, images or symbols, and should be used appropriately to facilitate understanding. Furthermore, having a shared and common language and terminology is imperative for relevant and accurate record-keeping and communication between teams and disciplines. In all contexts, ethical and professional communication must be underpinned by respect and integrity towards freedom of expression, alternative perspectives and views, and the ability to tolerate dissent. To respond professionally, social care workers should take the time to understand and respect the contributions of others and subsequently evaluate for context. This means utilising silence skilfully as a means for essential space for thinking and reflection; asking questions to obtain clarity and stimulate thinking; and observing to comprehend non-verbal forms of communication, formulate hypotheses about what is happening and test the reliability of our perceptions against those of other individuals and other information available (Trevithick 2005: 121-2). In doing this, we are creating and promoting an environment conducive to effective and professional communication that allows for informed and effective decision-making by all parties. Practically speaking, this involves the social care worker understanding the communication needs of the individual they are engaging with, meeting them at their level, and ensuring that they suitably express informed opinions in a manner that is clear, succinct and appropriate. Avoiding jargon, using suitable and clear vocabulary, adopting a communication style that is inclusive and encompasses the entirety of expression, including verbal and non-verbal interaction, is key to a social care worker effectively communicating in a variety of settings and contexts.

Communication facilitates collaborative practice between professionals in social care practice. Deviation from this can result in the needs of service users and families not being met, and a failure to position the service user at the core of decision-making. Healthy communication takes place in ever-evolving social circumstances that are impacted by external influences and interpersonal factors. How social care practitioners and service users communicate with one another has a significant impact on the quality of care and on health outcomes such as service user satisfaction with care and overall improvement in health (Street 2003). Social care workers can often find themselves in a role where they are offering support to service users as part of a multi-disciplinary team. Indeed, these communications take place between social care workers and service users, family members, healthcare providers and others. Interpersonal health communication exchanges are part of a complex social system that influences health knowledge, behaviours and outcomes through information exchange (Nelson *et al.* 2004).

Case Study 1

Rosy is 35 years old and has a moderate intellectual disability and, as such, a reduced capacity to understand and process new situations and experiences. This is further complicated by literacy problems and communication problems. Rosy is a service user in a residential programme in which you work as a social care worker. Rosy's parents are both engaged in her care and visit with Rosy regularly. A member of the residential social care team has noticed that Rosy has a lump on her side that is discoloured, and after they gave that information to the team, Rosy has had it explained to her that she would be going to the GP for a check-up. At this check-up the GP was sufficiently concerned about the lump that she has recommended Rosy go for a biopsy. As a social care worker, you have attended the appointment with the GP and will attend for the biopsy at the hospital. Rosy has noticed the lump and it has been causing her discomfort. The GP has explained to Rosy what is happening but is unsure how much of the situation Rosy has understood.

How can you support Rosy in understanding what is happening with her body and what the next steps are in her medical treatment?

Informed Opinions within Boundaries of Confidentiality

The boundaries of confidentiality are in place to keep the information of children, parents, carers and the members of staff confidential. It is the responsibility of all members of staff to keep the records of children and staff members, which contain personal information, safe and confidential.

As previously stated, the relationship between social care worker and client is dominated by a power differential due to the social care worker's access to sensitive information pertaining to the client, remuneration for their work, the relationship being led by the client's needs and the influence the social care worker has in terms of decision-making. In most settings, the social care worker will be considered the expert. Clients will therefore believe you have the knowledge and experience to develop informed opinions and subsequently to give these opinions authority. How a social care worker develops this informed opinion is of relevance here. Information-gathering occurs not just through direct communication with service users and their families but through observation, and through attending both team and multidisciplinary meetings.

The social care worker can subsequently be found at an impasse whereby they are in receipt of knowledge or information relating to the client that has not directly been shared with them by the client. The human nature of the work does not allow us to disregard or forget this information, regardless of professional boundaries. We are therefore faced with recognising the importance of sharing information relating to our clients on a 'need-to-know basis'. There is no scientific formula or direct theoretical guidance for making these decisions and so the social care worker takes the role of being discerning within the parameters of confidentiality, taking context, situation and time into consideration and ultimately their own professional intuition. Therefore, ethical decision-making is inevitably influenced by values, context and human fallibility.

It is in these situations that a scientific approach or formula may provide comfort and security to the worker, but in its absence the importance of the worker receiving support from their team and management when developing informed and considered opinions is imperative. Understandably, there is a culture of fear associated with making such informed decisions and the potential of negative professional repercussions due to a boomerang culture underpinned by accountability. What is meant by this is the acknowledgement that every decision made has the capacity to come back to the practitioner with significant professional implications. While accountability in practice is essential for quality and delivery of safe and effective care, it brings its own challenges and without adequate support can result in practitioners shying away from making informed and considered decisions.

An effective model of informed and shared decision-making that highlights the importance and benefits of inter-agency communication can be observed through Tusla's Meitheal partnership approach. Meitheal is a targeted, co-ordinated intervention for families who do not meet the threshold for social work intervention but would benefit from a multi-agency approach where agencies can communicate and work together effectively and respond to families with a range of expertise, perspectives, knowledge and skills. The service user is at the centre of deliberations and considerations and is privy to and involved in the decision-making process throughout.

Boundaries of Confidentiality in Relation to Information that must be Shared

According to HIQA (2012), confidentiality in the health and social care context refers to the duty a practitioner has to safeguard information that has been entrusted to him or her by their service user. A duty of confidence arises when one person discloses information to another in circumstances where it is reasonable to expect that the information is held in confidence, such as between GP and patient (HIQA 2012). In general, it is essential that social care workers respect confidentiality and keep sensitive information pertaining to the service user confidential. Deviation from this can have a detrimental impact on the therapeutic relationship and result in a breakdown of trust. Generally, sharing confidential information, even between professionals or family members, should require informed consent from the client. If service users are confident that their information is being appropriately protected this increases trust between practitioner, service and client, which could result in the client feeling comfortable enough to share more information, ultimately improving safety and quality of care at an individual level (HIQA 2012).

However, there are exceptions and boundaries of confidentiality and the right to confidentiality is not absolute. Situations can arise relating to safeguarding of vulnerable individuals where confidentiality cannot be maintained. It is important to have transparent and detailed conversations informing clients about the limitations and boundaries of confidentiality from the beginning of the relationship. This clarity provides security to both worker and client and also ensures that the client is informed from the start in relation to conditions where limitations of confidentiality exist and that, even though social care workers are responsible for promoting and protecting confidentiality, situations exist where this cannot be maintained or guaranteed. The professional's opinion about what to do in cases where confidentiality cannot be maintained is contingent on the degree and severity of the risk to the service user or another vulnerable party.

TASK 4

As a social care worker at the beginning of your career, can you think of a list of people who might appropriately influence your informed opinion-making process? Consider professional supports you would have access to and personal support networks the client may have.

Case Study 2

John is a 15-year-old boy who has been in the care of his maternal grandmother, Mary, since his mother passed away ten years ago. John's father is incarcerated and John has never had any contact with him. John has had a turbulent couple of years and has struggled in terms of engagement with education and youth reach. Currently, John is not engaged with any form of education and has come to the attention of the police several times in the last year for anti-social behaviour. John's placement with his grandmother has become unstable due to a combination of behavioural issues, anti-social behaviours and also the deterioration of his grandmother's health. The Tusla Social Work team have suggested the possibility of John moving to a residential placement. When this has been mentioned to John he has responded vehemently against the idea as he wants to stay with his family. Mary is upset by this idea of John being 'taken away' as she feels responsible as John's only family; however, Mary also accepts that she can no longer meet his needs in the home. As a social care worker in non-residential day services you have engaged with John over the past year and have developed a close relationship with the family. You are keen to support John during this difficult time. When you go to the house for your weekly session with John, Mary has asked you to explain what all of this means and what you think is the best option for John. Mary is upset that John is being 'taken away' but also acknowledges that she cannot meet his needs any more. The social work team have described to Mary the nature of residential care, but Mary's understanding is that it is a form of incarceration. John is scared that he is being taken out of the family home and that fear is being expressed as anger.

Now consider the following questions:

- What is your role as a social care worker in this situation? Consider effective and professional communication in your answer.
- How would you respond to Mary's questions about residential care in this context?
- What is your understanding of this situation in terms of professional boundaries and boundaries of confidentiality?

Final Thoughts

From a practitioner's perspective, it is imperative that we do not make promises pertaining to confidentiality that we cannot keep. If we do this we are in breach of and violating professional social care boundaries and subsequently putting our clients or other vulnerable individuals at risk. As previously stated, we frequently find ourselves in situations that call for careful ethical and professional decision-making and consideration of the SCWRB Codes of Professional Conduct and Ethics. Ensuring a commitment to our own professional boundaries will facilitate our ability to express professional, informed and considered opinions to service users, health professionals and others within the boundaries of confidentiality and will prevent us practising in an automatic, unthinking way. The juxtaposition that exists within practice that is concerned with maintaining boundaries, upholding rights of clients and the conduct and duties of social care workers compared to the narrative associated with choice, collaboration and care highlights the intricacies and human nature of social care work and the importance of understanding context, the complexity and sensitivity of the social care relationship and the need for a continued commitment to informed and knowledge-based practice.

Tips for Practice Educators

Understanding the context of the environment that students in the allied health professions will work in is key to effective practice education support (Mulholland *et al.* 2005). This context includes the interpersonal professional relationships that students develop within the placement environment. Students develop direct relationships with service users over time and through ongoing contact. However, students will also engage on an ad hoc basis with professionals from multi-disciplinary teams and personal support networks of these service users. Additionally, the interpersonal relationship and communication between the student and the practice educator plays an important role in the success of the placement learning experience (Mulholland *et al.* 2005).

An understanding of social context is also important in navigating these tricky and complex interpersonal relationships (Ackerson & Viswanath 2009). Social context requires an understanding of the impact of macro-level environmental factors such as socioeconomic disparity, ethnicity and race, access to social networks, social support and social capital. Additionally, communication inequality should be considered when expressing professional, informed and considered opinions to service users, health professionals and carers or relatives. Communication inequality is defined as differences among social groups in the generations, distribution, manipulation of information at the population level and access to and ability to take advantage of information at the individual level (Viswanath & Ackerson 2011).

How can you prepare a student for these different roles and interpersonal relationships?

- Keep the topic of boundaries on the agenda for both individual supervision and team meetings. Our boundaries have the capacity to change throughout our career and should not just be a focus during student placement. Encourage discussion relating to professional boundaries and ethical scenarios.
- Ensure that students understand the boundaries and limitations of their role. Interpersonal relationships can get complicated in any setting and this can be even more apparent when working with vulnerable populations (Cooper 2012).
- When possible, allow students to engage with and/or observe the functionality of a multidisciplinary team and the sensitivities associated with boundaries of confidentiality in practice.
- Ensure that those with practical and recent experience of their professions take on the role of practice educators. Kilminster and Jolly (2000) recommend that practice educators have at least one year full-time post-registration experience prior to taking on the practice educator role.
- Placement educators should support students in their various forms of interpersonal communication such as information seeking, observation, uncertainty management, and stress buffering (Nelson *et al.* 2004).
- An effective practice educator needs good communication and interpersonal skills as well as practice proficiency and the ability to facilitate learning opportunities (Mullholland *et al.* 2005).

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Chapter 33 – Bernie Breen

Domain 2 Standard of Proficiency 10

Understand and be able to recognise the impact of effective leadership and management on practice.

KEY TERMS

Management
Leadership
Power
Culture
Practice implications

Social care is … ensuring that particularly vulnerable people receive quality service provision where respect, dignity and unconditional positive regard are shown and always upheld.

Fundamental to social care practice, leadership and management is that the person receiving the care and support feels genuinely cared for and the environment reflects this. You may not remember what people say to you, but you will never forget how someone makes you feel. Where outcomes are concerned, that is the biggest outcome you can have for someone in your service – that they feel genuinely cared for. People in our services do not have a choice in why they are there, but we do have a choice as to the career we go into. We can leave or choose different options, but the people we care for do not have that option. There is no doubt that it is a stressful and challenging sector, but we made the choice to pursue it and must ensure we are in it for the right reasons and that we understand trauma-informed practice.

TASK 1

Take a pen and paper and complete the four leadership styles worksheet to identify your own style.

https://cdn.we.org/wp-content/uploads/2016/05/Part-2-Activity_Four_Leadership_Styles_May271.pdf

Leadership and management are crucial factors in any organisation, but particularly in social care, where vulnerable people rely on quality service provision. Having worked as a manager for a number of years, I am aware that quality service provision comes from the top down. When people think of leaders, they often think of people in well-paid positions of authority and official roles such as managers, people in charge and social care leaders. Although they may share similar characteristics and are often linked together in generic literature, there is a growing focus on leadership as being an essential component in social care management. It is important to realise that simply holding a managerial role does not necessarily make one a leader. It's commonly asked, Do good managers make good leaders? Do good leaders make good managers? A definitive answer can be difficult to come up with. We can, however, say with certainty that, although leadership and management are not contextually the same, in my view they are both essential for best practice in social care.

If managers are to be successful in their role, it is vital for them to absorb certain leadership skills. Likewise, if leaders want to be effective, they must understand how to manage their employees so that they feel inspired, empowered and connected, ultimately leading to quality care provision and a successful organisation. Managers and leaders need an understanding of human behaviour and personality traits to create a more engaged workforce and a more dynamic workplace. This in turns creates an environment conjunctive to best practice.

Management in Social Care

The term 'manager' refers to the person who is responsible for the effective running of a centre, or operations within an organisation, and co-ordinating and managing resources such as staffing and budgets. The manager is expected to have strong organisational skills and to hold a position of seniority. In residential social care the manager/person in charge (PIC), deputy manager, social care leaders, and people with various other titles, make up the centre's management team and set the culture within the organisation. Within these roles they provide supervision to staff and oversee the administerial requirements and work practices in the centre to ensure they run effectively. This governance should ensure that operations are running in line with national standards and legislative requirements, particularly, in residential centres, in relation to safeguarding. Job titles may vary, but the effective running and management tasks remain the same. In contemporary practice, social care workers are increasingly occupying leadership and management positions, in line with requirements from their Tusla service level agreements (SLAs). In contemporary practice, social care workers are increasingly occupying leadership and management positions, in line with requirements from HIQA requirements and Tusla service level agreements (SLAs).

However, a leader does not necessarily need to be in a position of authority to influence others.

Leadership in Social Care

Managers may effectively run the day-to-day operations but may not lead the team or inspire others to share the vision of the organisation or motivate people within their roles. Leadership can be defined as any behaviour that influences the actions and attitudes of others to achieve certain results. The ability to manage should be coupled with the ability to be a leader to achieve maximum efficiency. Leaders need to believe in themselves and their ability if they expect others to believe and trust in them. Knowing your own limitations is also essential as a leader and that can then be served and balanced by surrounding yourself with a team of varied skillsets that complement each other and work together in collaboration.

One aptitude that distinguishes leadership from many other competencies is the capacity to teach and mentor others. Effectively teaching staff, role modelling and directing creates professional growth. Often, this skill necessitates leaders thinking less about themselves and more about the team as a whole and how to create successful outcomes, and this requires drive, ambition and motivation to achieve planned outcomes and to cultivate more leaders within the team.

A key attribute in cultivating other leaders within the team is mastering the art of effective communication. As a leader, you need to be able to explain clearly and concisely to staff everything from the purpose and function and ethos of the organisation to specific tasks. Leaders must grasp all forms of communication, from one-to-one meetings such as formal supervision to group forums such as team meetings. They must also be able to communicate effectively by phone, email and webinar, considering what approach works best with each individual as well as the team as a whole. Professional development plans for staff are paramount in providing a sense of purpose and growth, and balanced feedback on performance should be provided through supplemental and formal

supervision. This creates a growth mindset. A leader cannot promote the leadership capacity of an employee through performance management alone. Evaluating performance leadership entails exploring the qualitative ways an employee has exhibited positive behaviour. When recognition and acknowledgement are given to the leadership attributes of staff members, they not only receive the support and encouragement they need to continue their journey as leaders, but they become better engaged with and content in their work overall.

TASK 2

Think of some leaders you admire. What makes them stand out to you? Why do you admire them? How do they influence others?

Power

Management and leadership positions denote a sense of power which, within the context, is legitimate. It can, however, be detrimental to organisations if the individuals in these roles see themselves as superior to others as human beings, not just by virtue of their positions. Attitudes are a pivotal part of what makes effective leaders. While accountability must be a part of managing performance of staff, if this is not balanced with support, it can seem authoritarian. This in turn may lead to people operating out of fear, which impacts on transparent practice and in turn promotes a blame culture. Respect is earned – it does not automatically come with an official job title. If staff feel they can openly admit to mistakes/errors of judgement and this is used as a learning and reflective tool, it will in turn lead to improved practice and reduce the incidence of such errors. Having said that, with all support and learning opportunities being provided, if there are safeguarding concerns or if individuals do not respond to this constructively, if they have a laissez faire attitude and do not adopt a professional approach to their work, then disciplinary procedures may need to be implemented.

TASK 3

Download a copy of the Workplace Bullying Power Control Wheel by Scott (2018) available from https://socialscienceandhumanities.ontariotechu.ca/workplacebullying/power-control-wheel.php

Discuss how the categories of power and control can exist in social care settings.

Culture

Ultimately poor leadership and poor culture impacts negatively on the staff team and the lived experience of the service users and there may be a controlling culture in place. This can also lead to greater instances of challenging behaviour, particularly if there is a culture of 'them versus us'. The staff team may feel disempowered or coerced into practices they may not necessarily agree with, especially in how they are instructed to relate to a service user group, for example a punitive as opposed to therapeutic approach. This can impact on the social care worker's confidence and motivation in their role.

Without being in a formal leadership/management role, we are, as practitioners, very powerful. We are the people who ultimately have control over the environment and daily running of the centres. Hanlon (2009) states that staff have the power to influence, ignore, coerce and manipulate but also have the power to intervene, identify the person's feelings, needs and wants and to make each day a positive experience and a learning opportunity. With increased governance through the inspection

processes, there is more emphasis on providing evidence for our work through report writing and record keeping. It must be said that this too gives power as practitioners generate the data and the data is only as good as the author and the culture in which we operate. Reports can be phrased in a way that frames the service user's behaviour as the issue. For example, the author might omit the actions practitioners took that may have become a trigger for the service user. A good leader should encourage transparent practice that reflects actual events, not how we want the event to be perceived. At times reports can neglect to identify all the positive aspects of the day and focus on the negatives. Significant event notification forms are generally negative and focus on an incident of behaviour that challenged or a behaviour of concern. There are positive significant events too, such as a young person engaging in school for the first time, or a positive overnight family access visit. It is important to report and record the positives – you can imagine how it would feel to access reports on your life in years to come and find that everything reads as negative. Recording these details also reflects not only the achievements in someone's life but also the progress and soft outcomes as well as tangible ones.

To ensure accuracy and transparency a manager or leader needs to provide supervision on the go, observing practice, not just seeing supervision as a formal process. A good leader will oversee paperwork and ask questions for clarification on daily logs and incident reports, for example, and use them as a source of learning. Exploration of the approaches and responses to service users should be discussed with the staff, ensuring that they are therapeutic. Outcomes should focus on natural consequences for behaviours as opposed to punitive sanctions. Exploration through debriefing of incidents is paramount to support staff and ensure accountability and learning for everyone. Positive organisational culture is engrained in any organisation by the leaders and managers.

Formal supervision should occur frequently or as per organisational policy. It is a dual process between the supervisor and the supervisee. The supervisor is usually the manager or deputy for full-time staff and social care leaders may be involved in the supervision of relief staff or students. A dual process means that both parties should be active participants and it should not be seen as a box-ticking exercise. Best practice would involve both parties having an input into the agenda, and the supervisee should be proactive in seeking supervision if for some reason it has not been scheduled or has been missed. The supervision process ensures that the supervisee receives focused time to reflect on work practice, professional development and feedback on their practice. There should be a balance between accountability and support. Leaders can ensure that the vision and purpose and function of the organisation are upheld and that expectations are clear. Staff should feel valued and motivated following the session. It is not a disciplinary meeting; neither is it a counselling session. In my experience supervision provides opportunities for workers to reflect on their practice in the following seven ways.

Supervision in Social Care Work
Workers can reflect on content and process of practice
Monitor and ensure the quality of work
Review and plan work
Consider any responsibilities and input of the supervisee
Develop understanding and skills
Seek and receive information, support and feedback
Voice and examine concerns.

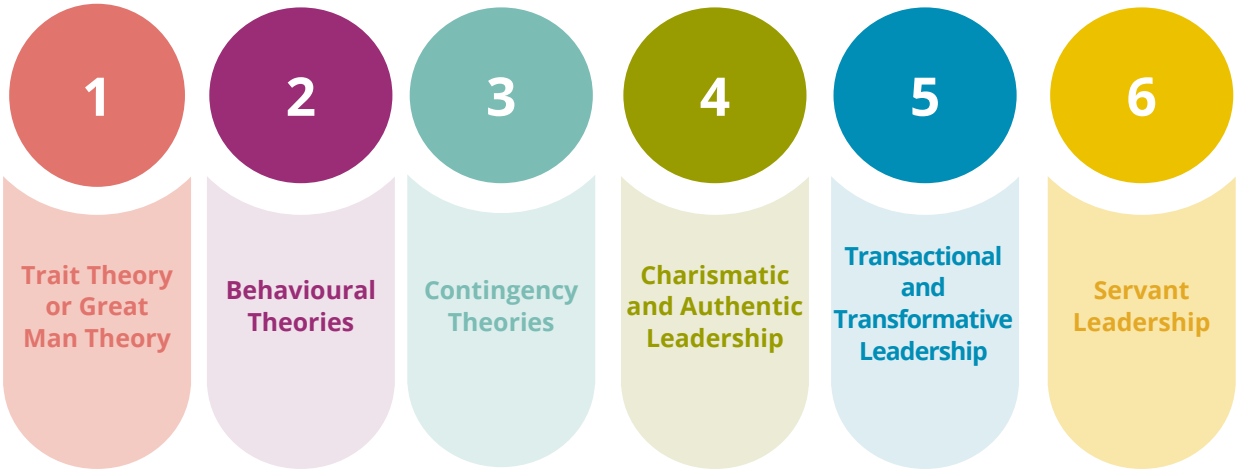
Central to the process is that both parties (supervisor and supervisee) should be trained in their role. Very often supervisors have said that they were given the task and role of supervisor, but were not adequately trained and they did not feel that they were equipped to provide it effectively.

Practice Implications

'Leadership is a process whereby an individual influences a group of individuals to achieve a common goal' (Northouse 2010: 5). Research by Hicks *et al.* (2009: 59) stresses the importance of getting the 'right personnel in place'. The leader should aim to improve the collective performance and should be able to take feedback from other members of staff without feeling threatened. It is important that managers and leaders recognise themselves as human beings who do not know everything, although they strive to be as informed as possible to inform others. It is okay to admit to not knowing something, as long as you commit to find out or to research more.

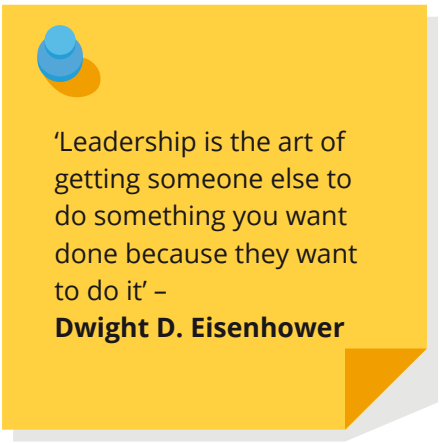
Social care environments often experience crisis-driven and difficult times. This leads to increased pressure on managers and leaders to oversee and manage complex care needs of service users, implement systems, support and debrief staff teams and participate in the multidisciplinary team with social workers, inspectors and other relevant parties. It is crucial, according to MacKian and Simons (2013), in order to ensure efficiency and to implement programmes supportive of the service users' needs, to endeavour to have the most effective managers and leaders in place. This extends to senior management to support social care managers and their management teams, particularly in challenging times, when they may feel isolated in supporting their teams, trying to stabilise the centre and ensure that service users' needs are being met. It is vital that support is provided and even a physical presence of senior management, who may usually be working quite a distance away, can provide reassurance to the leaders on site. During critical times, managers may be caught up in the crisis and therefore unable, emotionally, physically or because of time constraints, to provide the necessary supervision and debriefing. It is crucial that managers recognise this, seek support and are transparent about their capacity during these times in particular, and also that they engage in their own regular supervision and are themselves debriefed. Everyone is accountable to someone, and senior management will also need support from their peers and the board of management. They may require external supervision as their source of support as they carry the weight of their organisation.

The critical skills leaders require are to be able to manage diverse situations, comprehend relationships and their development, understand how people work and how the organisation shapes staff members' ability to function. An effective manager should also possess leadership skills to ensure that the organisation's vision is shared across all staff and to create a positive organisational culture. Therefore, it is important for leaders and managers to understand contemporary leadership theories and how they can influence their own development and approach.



It is important to understand the theories of leadership and how they relate to your own style to identify areas for professional and personal development to be versatile and adaptive. Much like the nature/nurture debate, leadership theories also debate whether you are born a leader or whether it is something that is influenced and developed. The great man theory and trait theory for instance suggest that leadership is innate, and people are born with the traits that lead them to attain powerful positions of authority. In contrast, the leadership skills approach sees leadership skills as being cultivated in individuals so they can develop into leaders. Contingency styles of management allow for the ebbs and flows within the complexities of social care and ensure flexibility and variations in approaches to respond effectively and appropriately to each situation.

The style approach then considers what people can do as opposed to how they are in the above theories. It looks at behaviour and attitudes, and incorporates interpersonal skills and relationships that the leader builds with the staff team.



MacKian and Simons (2013) critique the issue that research often focuses on management and leadership styles exploring the individual traits while ignoring the organisational influence and failing to critically analyse its impact on even the most effective leaders and managers. Northouse (2019) claims that it is advantageous to use the trait approach as a viewpoint for leadership and argues that research validates the basis of the trait's perspective. He states that a specific focus on the leader themselves leads to a greater understanding of this element of the process of leadership. To lead effectively, it is essential that managers themselves are managing their stress and receiving support (MacKian & Simons 2013).

In a caring management style, managers and leaders build on their own self-awareness and emotional intelligence to support staff, recognising them as emotive human beings. Professional development in leadership occurs in this process. Managers and leaders who developing emotional intelligence, MacKian and Simons (2013) argue, are more likely to retain staff, increase morale and increase productivity in times of stress. Ward (2014: 213) highlights the discourse for leaders in holding the responsibility for the wellbeing of children and staff while trying to self-care and states, 'it's not a position or state that one can take on, or put aside too casually', continuing, 'you need to be and feel on top of everything since you hold ultimate responsibility' (2014: 216). The position as a leader means you hold so much responsibility that trying to self-care at the same time is difficult or sometimes impossible – you cannot just put your responsibilities to one side.

When leaders are self-aware, they can become group-aware, which enables them to modify their own behaviour or responses to staff and situations. Increased self-awareness ultimately leads to constructive relationships in the working environment as staff feel listened to and understood, which generally leads to greater productivity. Self-awareness is something that is continually developed and involves constant reflection, not a one-off event such as a training course that becomes focused on achieving a certificate rather than putting what has been learned into practice.

An effective manager and leader should also recognise leadership traits in the staff team and recognise the influence they can have on the team. This can be both positive and negative as individuals can lead the team in actions that are not always positive for the manager or organisation. For example, if a staff member become demotivated or begins to speak negatively, this can influence others to think the same; suddenly there is a toxic atmosphere, which impacts on retention and staff turnover. If the same staff member receives praise and recognition for their efforts and perhaps is delegated areas of responsibility, they can influence progression and morale in a positive way. It is crucial to ensure that managers or leaders do not feel threatened but recognise the positive aspects. They should cultivate this by giving individuals tasks to utilise their strengths. Generally, this dissolves negative feelings and makes leaders in the team feel appreciated and recognised, but it needs to be managed if it is an issue or threatens the organisational culture or demotivates the team.

In my experience, I have identified six key elements in effective leadership that impacts positively on social care practice.

SIX KEY ELEMENTS OF EFFECTIVE LEADERSHIP
1. ***Positive Communication:*** This is considered one of the largest influencers in the workplace. If you choose praise and recognition over orders and criticism, the tone of your leadership will be set.
2. ***Gratitude:*** Acknowledging the hard work of the staff will increase morale, build trust, and create a strong and robust team.
3. ***Team Building:*** Create an environment where gossip or negativity is not tolerated and ensure value and respect are promoted within the team. Recognise strengths and areas for development and show that you are human.
4. ***Empower and Develop the Team:*** Create opportunities for learning. Provide and participate in training, share knowledge, and empower others to become leaders.
5. ***Take Responsibility:*** Admit mistakes and do not let others take the blame. This encourages others to do the same and creates transparency and trust.
6. ***Show Empathy:*** Emotional intelligence is a requirement in effective leadership. You need to understand where people are coming from even if you do not agree with them (i.e. group awareness). Showing empathy makes people feel understood and therefore leads to greater job satisfaction.

TASK 4

Read 'Lessons from Geese: A Better Way to Lead' by Lolly Daskal, available at https://www.lollydaskal.com/leadership/lessons-from-geese-a-better-way-to-lead/

Tips for Practice Educators

An important element for students' understanding of this proficiency is to experience and observe different leadership and management styles while out on practice placement. It will be useful to the student to make notes and reflect on the approaches and their impact on team dynamics, morale and productivity. In turn, they should reflect on their experiences and the impact of management on the service users' daily life events. How these correlate with the leadership and management in the organisation will form part of pivotal learning.

Students should be provided with a placement supervisor. This supervisor should be experienced and a member of the management team who can provide a platform for the student to reflect on their experiences and ask questions. This should be considered constructive feedback for the organisation as it is highly beneficial to see the perspective of the student from their placement experience and as a future practitioner and potential colleague.

It would be a positive experience for the student if they could attend training that is provided to the staff team as it will enhance their understanding of the core elements of care provision and allow them to form an association between the training and how it translates into practice. An activity could be introduced whereby the student creates a reflective piece to bring to a team meeting based on the training and the team can reflect and give feedback on how the core concepts are integrated into day-to-day practice. This would be a useful tool for everyone to see the concepts from a range of perspectives, to enhance the correlation of training and provide a great learning and professional development opportunity for the student.

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Chapter 34 – Gillian Larkin and Marian Connell

Domain 2 Standard of Proficiency 11

Understand and be able to discuss the principles of effective conflict management.

KEY TERMS

The brain and emotions

Emotional intelligence

Self-awareness

Conflict styles

Principles of conflict management

Social Care work is about being in relationships with another, compassionately understanding their narrative to help and support them to flourish in all aspects of their lives

This chapter will outline key principles of conflict management (Weinstein 2018), drawing on case vignettes from social care practice to help explore ways to manage conflict in social care settings. It will also explore emotions and concepts for developing your emotional intelligence and explore different conflict styles.

At its core, social care work is a relational-based practice (RBP) (Mulkeen 2020). Social care workers engage in relationships not only with service users but also with colleagues, and central to the development and maintenance of such relationships are the concepts of trust and respect, underpinned by the key theoretical framework from Rogers (1957) that includes empathy, congruence and unconditional positive regard, and working from a human rights-based approach. However, RBP understands that people are rational and emotional beings. According to McGarr and Fingleton (2020), the primary tool at the social care worker's disposal is the 'self', and the 'self' brings into these relationships all their experiences, values, beliefs, ideas, attitudes, feelings and behaviours. This view can be applied to the service user too, and when there are differences between people, conflict can occur. Higazee (2105: 1) posits conflict as a dynamic process that can be positive or negative, healthy or dysfunctional within a work environment. A common misunderstanding is that conflict is in some way a breakdown of normality, and is viewed as detrimental to those involved; however, conflict can lead to new ways of thinking, new practices and the growth and development of the people and the organisation (Everard *et al.* 2004).

In addition, social care workers play different roles, including care provider, advocator, educator, mentor and manager. These roles lead to various types of connection between social care workers and their service users, work colleagues and the wider multi-disciplinary team, including family members of clients, which increases the possibility of conflict within a social care environment. Keogh and Byrne (2016: 78) argue the need for 'social care workers to engage in ongoing continued professional development and professional supervision' to develop 'skills in managing resistance and/or defensive responses' that can contribute to conflict management.

Reflection

Why do social care students need to understand the principles of conflict management in a social care setting?

Before we explore what conflict is, take a moment to think about your experience of conflict in your home life. Are discussions viewed as an argument or an exchange of views? When there are disagreements, are they viewed as one person winning and one person losing? Do disagreements lead to silences? Fear? Anger? Rejection? Are disagreements avoided at all costs? Or do they lead to hearing another viewpoint, learning, and developing an ability to agree to differ?

How we view conflict and our experiences of conflict impact on how we engage in conflict; whether we see it as a battle or a learning experience, whether we view it as a winner and loser scenario, whether we embrace it or hide from it, or whether we see it as an opportunity for growth and development.

What is Conflict?

Conflict, defined by Doel and Kelly (2014: 21) 'is a group dynamic that occurs when there is a difference of opinion, or a disagreement regarding the work or functioning of the group'. Conflict is unavoidable and can occur between professionals, between staff and service users and/or their family members; thus, having the skills to manage conflict is essential in social care work.

Conflict between Professionals

Conflict may emerge within the team that we are working in or in a multidisciplinary team that we may work alongside. Unlike other professions, social care work is unique in several ways which can contribute to conflict arising, including workers spending much of their working hours sharing a daily living space with staff teams (Share & Lalor 2009), and working a shift with staff members who have different values and beliefs. Thus, the social care worker may have to use their conflict resolution skills to de-escalate conflict arising between themselves and colleagues, or, if they are in a management role, between staff members.

Conflict with Service Users

Service users engage with social care services to have their needs met. Sometimes it is their choice; at other times, such as when service users are placed in residential or foster care, they may have had no choice in who they live with or where they live. Additionally, social care workers may engage with service users who have experienced abuse or neglect, present with behavioural, psychological and mental health problems, disability or addiction that contribute to poor emotional regulation (Keogh & Byrne 2016), which may contribute to incidences of conflict. Conflict resolution skills are essential in this context.

Types of conflict (Hizagee 2015)

1. Intrapersonal conflict which occurs within one individual.
2. Interpersonal conflict which occurs between two or more individuals.
3. Intragroup conflict which occurs within one group.
4. Intergroup conflict which occurs within two or more groups
5. Competitive conflict which occurs when two or more groups attempt to reach a common goals
6. Disruptive conflict which results from trying to reduce or defeat the opponent.

While conflict can be healthy, Prendiville states that conflict is 'an indication of competition between people which has surpassed a healthy level' (2008: 65), and the figure above identifies different type of conflict that can be experienced (Higazee 2015). Scannell (2010) cites how unaddressed conflict can cause groups to collapse, while Jones *et al.* (2019) state that unresolved conflict in the workplace can cause low morale, poor performance, frequent absenteeism, and an increase in stress, combined with feelings of hostility, anxiety and anger.

Reflection

Reflect on the different types of conflict you have experienced working in a team.

What was your emotional response to experiencing conflict?

What strategies have you used to deal with conflict?

Can you link your response to your previous experiences of conflict?

To support social care workers in engaging in conflict resolution, learning commences in their undergraduate training where students have multiple opportunities to engage in exploring their core values and beliefs through practice-based professional practice, workshops and practice placement. This learning advises social care students to seek resolutions to issues that emerge with their peers through identifying emerging triggers and developing clear communication patterns and active listening skills. Excellent critical reflection and self-awareness skills are a prerequisite in assisting with this process and students are encouraged to adopt a more open-minded view of conflict while utilising a compassionate approach to themselves and others. These topics are explored in more detail later in the chapter.

Why does Conflict Occur?

Research carried out by the nursing profession (Jones *et al.* 2019; Marquis & Huston 2012; Kleinman2004; Tomy 2000) highlight many reasons for conflict – limited resources; competition between professionals; variations in economic and professional values; reform; poorly defined roles and expectations; the ability to work as a team; interpersonal communication skills – and these can be equally applied to the social care profession.

Case Study 1

Monieka, aged 12, is living in a residential care home. Due to an acquired brain injury Monieka is unable to understand when she is full, resulting in overeating. A plan devised with a dietitian that involved structured meal plans, portion control and treats was implemented. When Monieka's key worker was not working, staff in the unit brought Monieka out for treats to the tea shop and failed to adhere to her plan. At the team meeting, Anne, her key worker, was very cross and became red in the face and her heart raced when she talked about the plan not being adhered to. She became even more irritated when staff member Queen, raising her eyebrows, said it had only happened a couple of times and she was over-reacting. Paul, another staff member, said in a raised voice that he did not like his work to be analysed by staff not on duty.

- What is the cause of the conflict?
- Why did Anne respond as she did?
- What are the emotions emerging for the team?
- What are the reasons for the emotions?

What are Emotions?

While many emotions are universal;. Cultural differences are important to be aware of (Lim 2016).

According to Hockenbury and Hockenbury (2007), an emotion is a complex psychological state that involves three distinct components: a subjective experience; a physiological response; and a behavioural or expressive response. The first component, the subjective experience, relates to how we understand the emotion. To illustrate, the emotion of anger may translate into mild annoyance for one person to blinding rage for another. Emotions can also be mixed; for example, you might be excited and nervous about starting a new job, and these emotions can occur either together or separately. The physiological response relates to a physical reaction we experience when we have an emotion, e.g. sweaty palms, heart racing, shallow breathing, stomach unsettled, redness, trembling and so on. The behaviour response is the display of emotion, so the smile indicates happiness, the distorted face anger and so on.

We as social care workers spend a large part of our time interpreting the emotions of the service users we work with, but also of our colleagues. Equally, they are interpreting our emotions through our behaviour. Looking back to Case Study 1, we can ask: Why was Anne cross? Why was Queen dismissive of Anne's feelings? Why did Paul raise his voice? By being able to correctly interpret the emotional displays of other people, we can respond appropriately. This is very important in conflict as to not understand yourself or others can lead to a negative emotional response due to amygdala activity.

The Brain and Emotions

Have you ever completely overreacted to a stressful situation/person/event? This is known as an emotional overload or, as coined by Goleman (1995), an amygdala hijack. You usually know you have had an emotional hijack if afterwards you or someone else asks, 'What were you thinking?' The usual response is 'I wasn't thinking' and this would be correct.

Goleman (1995) argues that we usually process information through our cortex or 'thinking brain'; this is where logic (thought, judgement) occurs. However, there may be occasions where the 'thinking brain' is bypassed and signals are sent straight to the 'emotional brain' (limbic system). When this happens, there is an immediate, overwhelming emotional response disproportionate to the original event. The information is later relayed to higher brain regions that perform logic and decision-making processes, causing you to realise the inappropriateness of your original emotional response. In social care, there may be times when service users experience this kind of emotional overload, due to previous trauma and an inability to regulate their emotions. While social care students and workers tend not to experience this emotional overload, they can and do still experience an emotional response due to the activity of the amygdala. This can often be brought on by stress, fear, anxiety or anger and can result in conflict.

A stressful situation such as an approaching work deadline, service user/colleague difficulties, difficult tasks, role conflicts or emotional exhaustion can trigger a surge of stress hormones such as adrenaline, norepinephrine and cortisol that produce physiological changes such as the heart pounding, breathing quickening, muscles tensing, the appearance of beads of sweat and the 'fight-or-flight' response. This immediate emotional response was essential to early humans who were exposed to the constant threat of being killed or injured, so to increase survival, the fight-or-flight response evolved – an automatic response to physical danger that allows a person to react quickly without thinking.

In today's world, you are unlikely to experience the same threats as our forefathers; however, you are likely to experience other kinds of threat, such as behaviours that challenge from service users or colleagues, people in in your daily life, and stress. When you sense danger is present, your amygdala automatically activates the fight-or-flight response. However, at the same time, the frontal lobes in your neo-cortex are processing the information to determine if danger really is present and, if so, the most logical response to it. When the threat is mild or moderate, the frontal lobes override the amygdala, and you respond in the most rational, appropriate way. However, when the threat is strong, the amygdala acts quickly. It may overpower the frontal lobes, automatically triggering the fight-or-flight response, which while not leading to a hijack of emotions, may lead to you reacting, resulting in negative behaviours such as raised voices, silence, avoidance, withdrawing or forcefulness, which impact the individual, the work environment and often the service users (Howard 2004).

Case Study 2

Sarah regularly cleans out the bedroom where staff stay when on a sleep-over. One day, she unknowingly throws out Martin's toiletries, which he always leaves in the wardrobe. The next day, Martin discovers his toiletries are missing and erupts at Sarah. She responds by saying he should have clearly marked them as his belongings. They both leave this exchange feeling angry: Sarah feels under-appreciated for the work she does to clean the staff bedroom while Martin feels that no one respects his personal belongings.

- What is the cause of the conflict?
- What are the emotions emerging for Sarah and Martin?
- What has been left unsaid?
- How might this be resolved?

The Amygdala Response and Conflict

To gain a better understanding of what happens when we experience a threat or stress which can result in a fight-or-flight response, let's look at Mary's experience:

> *I was in a disagreement with a colleague who would not let me speak and constantly talked over me. I started to experience some* ***physiological responses – my heart rate increased, my breathing became rapid, my body started to shake, and my voice was quivering. The active amygdala also immediately shuts down the neural pathway to my prefrontal cortex,*** *so I become disoriented in the heated conversation. I was unable to make any kind of decision and could not see my colleague's perspective, only mine. As my attention narrowed, I found I was only concerned with my safety, which in this instance was 'I'm right and you're wrong.' Even though I knew my colleague well I could not remember a positive thing about her. [****When our memory is compromised like this, we cannot recall something from the past that might help us calm down and instead we feel the amygdala indicating 'Danger, react. Danger, protect. Danger, attack.' When the amygdala is active, we cannot choose how we want to react because the old protective mechanism in the nervous system does it for us.]*** *I shouted at my colleague to be quiet, which resulted in my colleague snapping back at me.*

How to Manage Conflict

Key Learning

Self-awareness and reflection have been described as the cornerstone of professional development in social care practice (Greene 2017: 1) and both concepts play an important role in reducing and resolving conflict.

Key to managing conflict is not allowing our emotions drive us and making sure to **respond and not react**. In the example above, Mary allowed her emotions to take over and she reacted to her colleague, rather than responding. To manage conflict constructively, we need to be able to take charge of our emotions; in essence, we need to be able to override our automatic response to a threat or stress, as this will enable us to respond more appropriately.

Self-Awareness

Self-awareness is the exploration of our feelings, behaviours and thoughts. It is about recognising our skills and limitations and what impact they may have on others. It is also about recognising how external and internal events affect us and how we respond to them (Sharples 2013, cited in Stonehouse 2015: 1). Hayes (2004: 37) states that 'the more we are aware of our values, beliefs and attitudes (and how these affect the assumptions we make about ourselves, others and the situations we encounter), the better equipped we will be to read the actual or potential behaviour of others and to construct effective courses of action in accordance with our reading.'

The Role of Emotional Intelligence (EI)

In a nutshell, emotional intelligence is the ability to recognise and understand emotions and use this awareness to manage yourself and relationship with others.

Emotional intelligence (EI) has been identified as an important component of self-awareness. EI has been noted as playing a significant role in positive workplace outcomes, and that includes managing conflict constructively (Schlaerth *et al.* 2013). EI has been defined as the individual's 'ability to motivate oneself and persist in the face of frustrations; to control impulses and delay gratification; to regulate one's moods and keep distress from swamping the ability to think; to empathise and to hope' (Goleman 1995: 34). Employees who have high levels of EI can accurately perceive, understand and appraise others' emotions and build supportive networks.

They are also considered more interpersonally sensitive and understanding, warm, protective of others, less critical and deceitful, and more likely to turn to the better perceivers for advice and reassurance (Abas *et al.* 2012). Howe (2008: 12) notes that the emotionally intelligent worker understands that emotions affect behaviour, beliefs, perceptions, interpretations, thoughts and actions. If you have EI competence you will understand when a friend is feeling sad, when a colleague is angry, and you will understand when you are angry, sad, happy, scared. This knowledge will enable you to manage your emotions in a more positive way, which can reduce or eradicate conflict. Daniel

Goleman's (1996) model of EI comprises five realms: know your emotions, manage your emotions, motivate yourself, recognise and understand other people's emotions, and manage relationships (others' emotions), and these are broken into four quadrants as detailed in the diagram below.

Figure 1: Emotional intelligence model (Goleman 1998)

	Recognition	Regulation
Personal Competence	**Self-Awareness** • Self-confidence • Awareness of your emotional state • Recognising how your behaviour impacts others • Paying attention to how others influence your emotional state	**Self-Management** • Keeping disruptive emotions and impulses in check • Acting in congruence with your values • Handling change flexibly • Pursuing goals and opportunities despite obstacles and setbacks.
Social Competence	**Social Awareness** • Picking up on the mood in the room • Caring what others are going through • Hearing what the other person is 'really' saying.	**Relationship management** • Getting along well with others • Handling conflict effectively • Clearly expressing ideas/information • Using sensitivity to another person's feeling (empathy) to manage interactions succesfully

Becoming more self-aware through increased awareness of how we are perceived by others is important for our emotional development. For example, it allows us to reflect on the emotional impact of our behaviours on others and can enable us to change our behaviours and regulate our emotions more efficiently. In essence, EI competence can reduce conflict. Although conflict is a main function of work culture, it leads to desirable outcomes only if resolved constructively and managed effectively (Schlaerth *et al.* 2013). To think rationally and respond rather than react emotionally, we need to allow the information to reach the logical part of the brain and we can do this by becoming aware of our emotional triggers and learning to take a moment before reacting. This is achievable through having EI competence, and according to Salovey and Mayer (1990) EI competences can be learned and developed,[1] so students and workers can cultivate skills that support conflict resolution.

Awareness about your Conflict Style

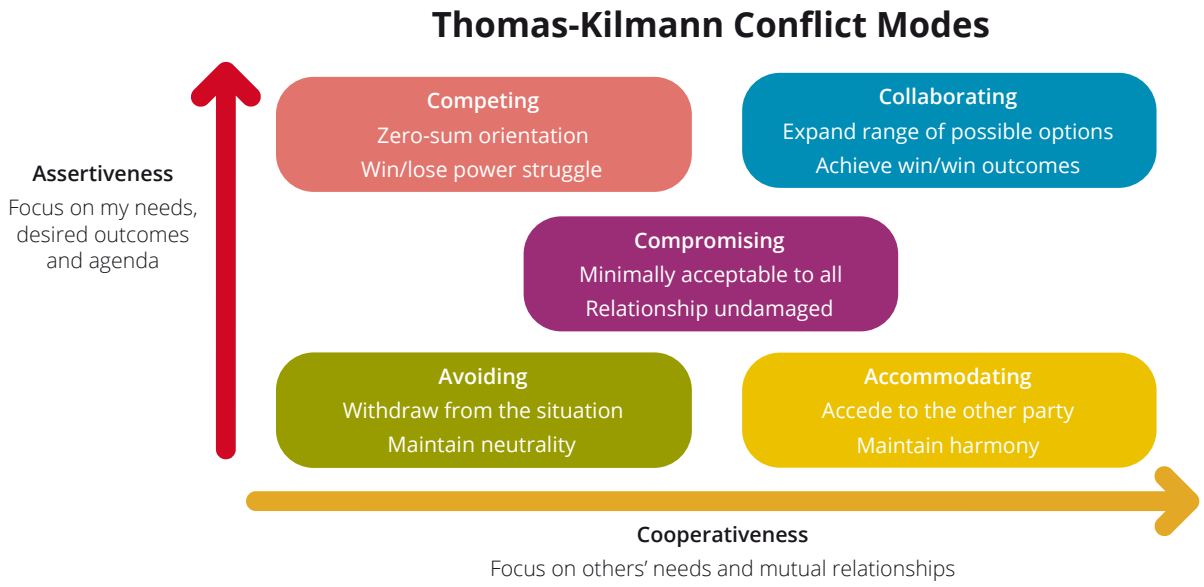
In addition to developing EI competence as a means of managing conflict constructively, an individual can learn what conflict style they have. The Thomas-Kilmann conflict mode instrument (TKI)[2] has been used successfully to help individuals in a variety of settings understand how different conflict styles affect personal and group dynamics. The TKI measures five 'conflict-handling modes', or ways of dealing with conflict: competing, collaborating, compromising, avoiding and accommodating. These

1 Resources to discover more about EI, questionnaires and exercises to increase EI:
https://positivepsychology.com/importance-of-emotional-intelligence/
https://positivepsychology.com/emotional-intelligence-skills/
https://positivepsychology.com/emotional-intelligence-frameworks/

2 This Kilmann diagnostic website provides a range of resources, research and instrument to determine conflict styles:
https://kilmanndiagnostics.com/overview-thomas-kilmann-conflict-mode-instrument-tki/
This document provides the instrument and interpretative report:
http://www.lig360.com/assessments/tki/smp248248.pdf

five modes can be described along two dimensions, assertiveness and co-operativeness. Assertiveness refers to the extent to which one tries to satisfy one's own concerns, and co-operativeness refers to the extent to which one tries to satisfy the concerns of another person (Thomas & Kilmann 1974 2007).

Figure 2: Models of conflict management (Thomas & Kilmann 1976, cited in Darjan & Tomiță 2015)



In essence, the Thomas-Kilmann instrument (TKI) evaluates the behaviours of individuals in a conflict situation, how they react to certain situations and what is the most appropriate way to intervene (Ciorţă 2020). Those using the competing style demonstrate a high concern for self, which is evidenced by the need to maximise individual gain, even at the expense of others. At the other end is the collaborating style, which seeks to find solutions to meet the needs of all involved. The avoiding style disengages from conflict completely, demonstrating a low concern for self, while the accommodating style puts others' needs before one's own, thereby sacrificing self-interest. Those with a compromising style tend to stand between co-operativeness and assertiveness and make concessions so that a resolution can be found (Thomas & Kilmann 1974).

This model does not assume that individuals have only one style in managing conflict, but it does suggest that they may have a preferred style that they defer to in conflictual situations. Similarly, the model does not purport to state that only a collaborating style is always the most suitable, but rather different style may be relevant to different situations (Darjan & Tomiță 2015). For example, if an issue is not important and confronting may be time-consuming, the avoiding style may be best. However, if the issue is considered important, a competing style may be used. If we refer to Case Study 1, it could be assumed that Anne, the key worker, sees the issue as important and will use a competing style.

In helping to manage conflict effectively, it might help to ask the following questions, as the response may be influential when selecting a conflict style:

- How much do you value the person or the issue?
- Do you understand the consequences?
- Do you have the necessary time and energy to contribute?

Reflection

When conflict occurs, a social care student or worker has a choice – they can either react in a way that creates more conflict or respond in a way that create growth and harmony. According to Hocking (2006), when in conflict, professionals tend to use three styles to handle the situation – avoiding, forcing behaviours, and negotiating. This demonstrates that people usually deal with conflict in unhealthy ways, by either suppressing it or escalating the conflict. Suppression can include avoiding conflict, yielding during conflict, and withdrawing during conflict. Escalation can include forcing others, manipulation, being argumentative, threats. The use of reflection can help a student or worker to manage conflict in a healthy way.

Reflection is the purposeful rethinking of an action, the beliefs driving it and the resultant outcomes, to gain insight and understanding. Reflection enables the individual to step back and become critically aware of the assumptions, beliefs, values, hunches, biases and justifications that are pulling them into the conflict, and thereby provide insight through self-evaluation (Hocking 2006: 255). This reflection can occur prior to entering a conflict as well as throughout and after it, and it can help us avoid destructive scenarios, and create new communication patterns. While it can be a challenge to consider reflection when it feels like you are under threat or stress, the ability to pause and reflect does provide significant help. By taking the time to reflect, we are more likely to make some space within ourselves for understanding the actions, behaviours and viewpoints of ourself and the other person.

Using the iceberg analogy, what we see in others is what is above the surface: tension, silence, withdrawal, stress, exhaustion, anger and disappointment. What we do not see is what is under the surface: fears, sadness, vulnerability, powerlessness, self-doubt and other beliefs that drive others to protect themselves[3] (University of Florida 2017). They equally only see what is above the surface in us too, and without self-awareness, EI and reflection, there is a propensity to view just the behaviours, which can result in conflict occurring.

Examples of Conflict in Social Care Practice

Case Study 3

Cathy is sitting in the office fuming. This is the third shift she has worked with Robert where she has had to make the dinner and he has done nothing to help. Cathy spoke to Mary and Princess about Robert not helping and they laughed and said, 'Ah, Robert just comes to the table hungry, like the kids.'

What is the cause of the conflict? How might the conflict be resolved?

3 This resource offers different questions you can ask to increase your knowledge of self and healthy conflict resolution: http://training.hr.ufl.edu/resources/LeadershipToolkit/job_aids/Mastering_Conflict_Through_Self_Awareness.pdf

Case Study 4

Paul is Tommy's key worker and is part of the care in review team. As Tommy is leaving the unit soon, discussions are ongoing as to where Tommy might live. Paul has been advocating for Tommy to go and live with his aunt as he has a good relationship with her and her family, and he will be near his mum, so building relationships will be possible. Tommy's social worker, Kay, considers another residential unit the best option for Tommy, due to ongoing behavioural issues. Paul is aghast at this suggestion and engages in a very hostile manner with Kay. Voices are raised and Paul is asked to leave the meeting to calm down.

What do you think has caused this conflict? Review it from Paul's point of view.

Review it from Kay's point of view.

How might a resolution be found?

Whether you are a student, a social care worker or a manager it is important to understand how conflict arises, the causes of conflict, and the best ways to defuse conflict situations or to prevent them escalating. Conflict cannot always be avoided and while the above aspects of EI and knowing and understanding our conflict styles can help us to manage ourselves though self-development and awareness, we need to know how to manage conflict when it arises. Weinstein (2018) has articulated seven principles to effective conflict resolution, which will enable both an individual and an organisation to understand, discuss and resolve difficult situations.

Seven Principles of Conflict Management

The first principle is *acknowledging the conflict*. Often when conflict arises, an individual may worry about it, avoid the person they are having the conflict with, talk about the person behind their back and so on; however, this often leads to an increase in stress and anxiety about the issue and it can grow 'bigger', so it is best to accept that there is a conflict. Weinstein (2018)[4] states that at this stage you may be acknowledging the conflict just to yourself, but it is important to do this as it allows you to reflect on what happened, what caused the conflict, how you feel; and this reflection can help to bring some clarity to the situation. Wachs (2008) describes this as assessing the situation, and it is preparation for the next principle, which is to *take control of your response*. Here our EI competencies can help. If we have good awareness of ourselves and our triggers, and understand the impact we have on others, we are likely to be able to respond in an appropriate way. Similarly, if we are sensitive to the other person, we are likely to understand what they are feeling and thinking, and their emotions. If action is required, it is best to think clearly about the conflict – the issue, your feelings, the choices available to you – before you respond. Often, it is safest to take a break as this allows you to step away and think logically rather than emotionally about the issue, and thereby avoid an emotional reaction, which can lead to consequences for you.

4 Weinstein's *The 7 Principles of Conflict Resolution* (2018) offers an in-depth appraisal of conflict and ways to resolution with a variety of activities and case studies to support understanding and development in this area.

The next principle suggests that you *construct a resolution* using a conflict resolution framework (Weinstein 2018). In Weinstein's framework there are two steps: the first is to prepare the conversation: this includes areas such as managing your physical and emotional response, writing down your initial fears, wants and needs, accepting responsibility for how you act and respond in the dialogue, ensuring that you have all the correct information, and identifying potential outcomes. In the second part of the framework, where you are talking to the other person, use active listening, paraphrase and summarise to ensure clarity, and be aware of the importance of body language. When responding, Wachs (2008) highlights the importance of using words appropriately so they do not hurt and emphasises speaking factually, using 'I' statements, using words such as 'and' and 'instead', rather than 'but', as the former can lead to constructive discussions, while the latter can lead to a defensive response. The Thomas-Kilmann framework is useful at this stage as our style is very important in the negotiation element of conflict.

The first three principles can lead to an effective resolution between parties: however, if resolution cannot be reached, principle four discusses *managing the resolution via a third party*. This person will generally have a vested interest in the matter being resolved and could be the unit manager, or a colleague of the two parties. Their role is nonetheless one of neutrality and of ensuring a satisfactory outcome.

Whether conflict is resolved by the parties or via a third party, Weinstein (2018) discusses the importance *of creating a culture of early conflict resolution* and this is principle five. This means creating a context in which all people in the organisation can accept their role in conflict and use such situations to increase learning. This does require a cultural shift within organisations: the use of policies and procedures, conflict training, identified 'resolution agents', coaches, mediators and a positive attitude towards conflict modelled from senior management supports the development of a new culture. When addressing conflict and ways to resolve it, the role of the manager or team leader in a social care setting cannot be undervalued. Part of their role is to contain and hold feelings that arise out of conflict and facilitate appropriate ways of expressing these emotions to bring about resolution for their team (Winnicott 1964; Bion 1959). This may be achieved through formal or informal supervision, peer support and mentoring, debriefing following a critical incident and open and honest discussion at team meetings.

Principle six is *walking the walk*. This is a particularly important part of conflict resolution. Weinstein (2018) posits that if we belong to a culture that accepts and engages with conflict, we need to take responsibility for our behaviour and conflicts at work and with the relationships we have with the people we engage with every day. How do we respond to conflict? Do we contribute to conflict? Are we willing to look at how we respond and react? To help us, Weinstein provides the CAN inventory, a quick personal check that we can run through daily to raise our **C**onsciousness about the conflicts in our lives, **A**cknowledge them as potential triggers for change and growth and **N**ow take action.[5]

The final principle discussed by Weinstein (2018) is the *necessity to engage the safety net*. In some instances, informal resolution will not work, so it is important for the individual to know what polices are in place within the work environment should a resolution not be possible.

5 For more detail on the CAN inventory go to: https://learning.oreilly.com/library/view/the-7-principles/9781292220949/html/chapter-010.html.

Summary

7 Principles of Conflict Management

Principle 1: Acknowledge the conflict

Principle 2: Control your response

Principle 3: Construct a resolution

Principle 4: Discuss managing the resolution via a third party

Principle 5: Create a culture of early conflict resolution

Principle 6: Walk the walk

Principle 7: Engage in the safety net (Weinstein 2018)

TASK 1

Revisit Case Studies 3 and 4 and consider how you would apply Weinstein's (2018) seven key principles to resolve the conflict emerging.

1. Identify a situation where you recently experienced conflict.
2. What was your emotional response?
3. What differing viewpoints, values or beliefs created the conflict?
4. How did you resolve the conflict?
5. What could you have done differently?
6. Identify skills and competencies that you drew on to resolve the conflict.
7. What policies, legislation and support are in place to support you?

Tips for Practice Educators

Tips for Conflict Resolution for Students/Practice Educators/Managers

- Accept that conflict can be positive and can lead to growth and development.
- Take responsibility for your responses.
- Acknowledge conflict and 'take a breath' before responding.
- Use supervision as a means of reflecting on practice and learning and developing new skills in managing responses to difficult situations (Keogh & Byrne 2016).
- Engage in continuous professional development to understand self and emotional responses (Keogh & Byrne 2016).
- Create a culture of openness and commit to improving staff communication mechanisms and make discussions part of team meetings.

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Chapter 35 – Natasha Davis-Dolan

Domain 2 Standard of Proficiency 12

Understand the need to work in partnership with service users, their relatives/carers (if appropriate) and other professionals in planning and evaluating goals and interventions, as part of care planning and be aware of the concepts of power and authority in relationships with service users.

KEY TERMS

A partnership approach

Key skills and qualities

Social care in practice – case studies

Power and authority

Social care is … the provision of professional care, protection and advocacy for and on behalf of vulnerable people and groups across the life span. Social care workers identify areas of need where support is required and implement solutions and interventions to address these needs. A partnership in social care involves two or more individuals or organisations working together towards a common goal or shared interest.

Introduction

Social care workers are employed in a wide range of settings supporting children and adults who experience disadvantage, discrimination, social exclusion, prejudice, marginalisation and oppression. Working with children and young people in care and aftercare, I have experienced first-hand the importance of adopting a partnership approach with service users, with parents/carers and with other services. This proficiency highlights the importance of adopting this approach in order to meet the needs of service users. McArthur and Thompson (2011) advise that the effectiveness of family support work is dependent, in part, on working in partnership and applying a child and family-centred approach when addressing the needs of children and families. Fahlberg (2012: 239) stresses the need to establish a partnership with parents when it comes to decision-making as '*no matter how scanty their knowledge, at the outset of case interventions and planning, the parents know more about their child than anyone else*', therefore, '*for the sake of the child and the parents both, an alliance must be built with the family*'. Research conducted by Gilligan (2019: 226) on the Irish foster care system reiterated the importance of working with service users, relatives and carers, confirming that a '*stronger emphasis on person-centred work with children in care and their family members*' is required.

> 'Person-centred processes focus on ways of engaging that are necessary to create connections between persons' (McCormack *et al.* 2021: 29)

This chapter will focus on children and young people in care and aftercare and it will highlight the importance of and the relationships required to work in partnership and ultimately support the achievement of better outcomes for children and young people in care and aftercare. These relationships include the social care worker and the child or young person; the social care worker and the parents/carers; and the social care worker and other professionals and services. The ability to build relationships and work in partnership in social care requires certain skills and qualities which are the building blocks to a mutually respectful and trusting relationship.

Building a partnership and the achievement of better outcomes is not without its challenges (Lalor & Share 2013: 252). However, equipped with the necessary skills and attitudes, the social care worker can successfully build a partnership. This chapter aims to promote awareness regarding the need for a partnership approach in social care and demonstrate, through the use of fictional case studies, how building partnerships is essential when working with these client groups. Three practical case studies are provided, upon which the student can examine, discuss, reflect upon and find solutions to best work through the underlying problem which acts as a barrier to the development of an effective partnership. Each case study, while not based on true events, are situations which can arise when working with children and young people in care.

The Partnership Approach in Social Care

The rights of children in Ireland are protected by:

- Child Care Act 1991
- Children First Act 2015
- Children First: National Guidance for the Protection and Welfare of Children
- United Nations Convention on the Rights of the Child.

Section 45 of the Child Care Act 1991 places a statutory obligation on Tusla, the Child and Family Agency, to make determination as to the support required for young people making the transition from care into aftercare. The Child Care Amendment Act 2015 requires that Tusla prepare an assessment of need and an accompanying plan for young people progressing to aftercare which identifies the needs of the young person and the supports required to achieve those needs (Tusla 2017). Child-centred planning, such as an aftercare plan, ensures that children and young people are heard and that the welfare and best interests of the child and young person are of the utmost importance. Access to parents is also the right of a child, reinforced by Article 9(3) of the United Nations Convention on the Rights of the Child. In situations where a child is separated from a parent, such as when placed in the care of the state, the Convention provides for the child to have access to one or both parents. The Convention places obligations on state parties to '*respect the right of the child who is separated from one or both parents to maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child's best interests*'.

In order to realise the rights of the child or young person, the social care worker and other professionals work in partnership with the child as part of a care planning process. This provides for the child's voice to be heard in the decision-making. The Children First Act 2015 and *Better Outcomes, Brighter Futures: The National Policy Framework for Children and Young People 2014-2020* (DCYA 2014), place certain obligations on those working with children to promote the achievement of the five national outcomes, which include safety. In order to achieve this outcome, Tusla (2015: 11) advises that:

> '*Children and families are most likely to do well if they are provided with appropriate support in a timely fashion that is well coordinated, with good communication and partnership working between all professionals. From both a policy and practice perspective, partnership with families and between key agencies is essential. There is a need for on-going dialogue between parents, children and service providers to ensure that all those involved contribute to common solutions.*'

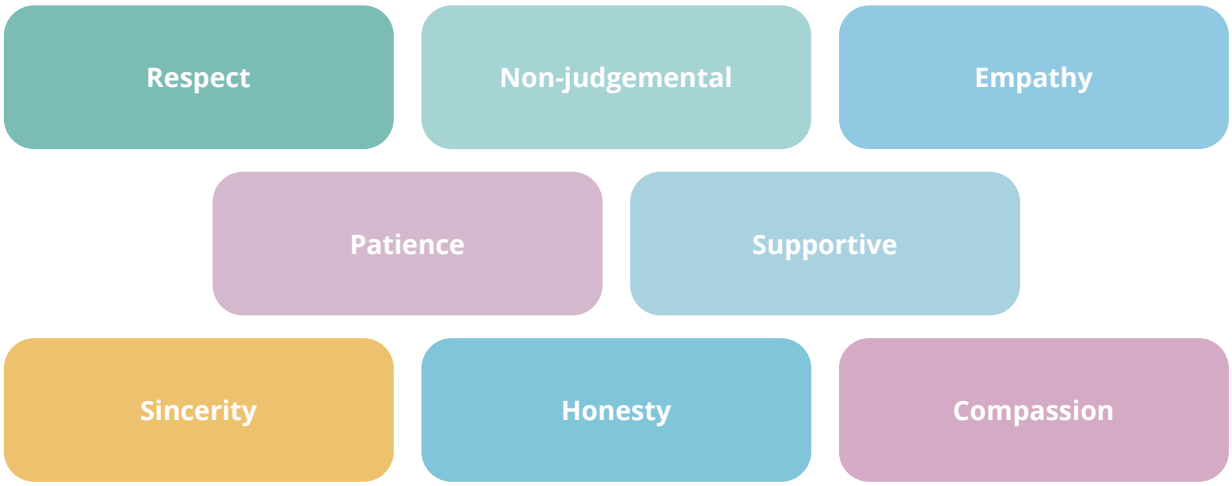
TASK 1

Read Chapter 38 by Des Mooney for information on how professional partnerships are achieved through inter-agency collaboration.

A need also exists to increase the child's participation in care and care planning (Gilligan 2019: 224). There is anecdotal evidence that suggests that children in care and aftercare display characteristics such as anger and suspicion towards adults. This is indeed my own experience with children in care and highlights the necessity of a partnership between the social care worker and the child or young person. Lalor and Share (2013) suggest that building relationships with children and young people in care may prove challenging as the child or young person may have no previous experience of a trusting relationship. Therefore, the social care worker must work in partnership to support the child or young person through direct work, building trust to establish a safe place where the child or young person can feel comfortable and secure in expressing personal needs and goals. Parents whose children have been placed in care may experience displaced anger towards the social care worker and other professionals (Fahlberg 2012: 192). This anger, coupled with raw emotion and mistrust, can result initially in a volatile partnership that may take time to build, where the social care worker has to work harder to support the parent in building the confidence and capacity to parent well. Chapter 38 provides a detailed insight into professional partnerships through inter-agency collaboration resulting in better outcomes and will therefore not be discussed in detail here. The following table outlines the benefits of creating partnerships.

The Benefits of Working in **Partnership** when Evaluating Goals and Interventions
• A partnership builds trust where the voice of the child or young person is heard and both child and parental autonomy is respected.
• A partnership provides for a child-centred and family-focused approach.
• Working in partnership and encouraging participation in care planning and decision making is shown to reduce anxiety and stress in both children entering care and their parents (Moran *et al.* 2016: 12).
• Building a partnership with service users, parents/family and other services can act as a protective factor which Moran *et al.* (2016) advise is '*a person, process or system that helps to protect a young person from circumstances or risk factors that could adversely affect their quality of life or life chances*' and includes '*both formal policy measures and programmes aimed at improving young people's lives*'. Biological family members such as grandparents and siblings, according to Moran *et al.* (2016), can provide a protective factor for children and young people in care and aftercare and help to support a smooth transition from aftercare to living independently.
• Partnership with other services and professionals promotes shared learning through interagency collaboration promoting increased efficiency in the delivery of support and service (McArthur & Thompson 2011).
• A partnership approach can empower parents to become better parents, supporting them to work through problems and find solutions.
• The inclusion of foster parents in care planning and a partnership approach regarding the child promotes positive fostering outcomes (Lietz *et al.* 2016), while Moran *et al.* (2016) advise that a collaborative approach which increases the participation of the child and all relevant adults in the care planning process can promote positive care experiences and better outcomes for the child.

Key Skills and Attitudes Required for Quality Partnerships



The key qualities and skills illustrated above are the building blocks required to develop and effectively build a partnership or relationship with a child or young person in care, a parent who may have children in care, a carer such as a foster parent, or another service which impacts on the child's life, for example school, disability and mental health services, aftercare services and psychologists. Key qualities include compassion, patience, supportiveness, empathy, a non-judgemental attitude and respect. Corless *et al.* (2017) also identify patience, empathy, a non-judgemental attitude, respect, and honesty as some of the key skills and qualities which contribute to rewarding relationship and partnerships in family support. Sincerity, patience and genuineness were also noted as key skills. Communication skills, self-awareness and self-reflection are also essential, including reflection on any bias which may act as a barrier and slow down or prevent the establishment of a mutually respectful partnership. The building blocks to quality partnerships remain unchanged regardless of who they are with. The skills utilised are not going to change when communicating and working in partnership with a service user or when supporting a parent or another service provider. Where a caseworker displays a positive, caring and nurturing attitude towards birth parents, the probability of the parents experiencing positive change and growth increases (Fahlberg 2012: 237). Person-centred care and person-centred care planning provides the service user with a forum to communicate and be heard. However, the service user must trust that the social care worker will support the attainment of personal goals. This trust results from a partnership which was built step by step, block by block.

TASK 2

Review the reflection guide below and write down the answers to the questions posed on the potential gaps in your knowledge, skills and personal development needed to build partnerships.

Social Care in Practice

These three case studies provide examples of a partnership approach to social care work.

Case Study 1

Maria

Week 1

Maria is a young mother who has two children, aged 3 and 5 years. The children were placed in foster care two months ago, due to neglect. Maria's capacity to parent was seriously impacted by an addiction. Maria voluntarily entered into a rehabilitation programme for this addiction. Supervised access for Maria and her children has been organised by the social work team. You are assigned to meet the foster parents with the children on the morning of access and then meet Maria at a local Tusla building for a 1.5 hour fully supervised access visit. The foster parents are quite anxious leaving the children. Mum arrives and is very excited to see the children, and they embrace. On entering the room in which the access is to take place, you observe many toys, blocks and colouring materials. Maria sits down and begins to talk to the children. The children appear to enjoy this time with Maria but are young and soon become bored. John, who is 3 years old, starts to cry and Billy (5 years) runs round and round the room in circles. Maria appears deflated and hands Billy her phone to look at cartoons. The children then sit watching the cartoons and do not engage any further with Maria despite her many attempts.

- What can you as a social care worker do to enhance this valuable time for Maria, John and Billy?
- How can you work in partnership with Maria to encourage her to become more involved and interactive with her children?
- Is there a need to also work in partnership with the foster parents and the children?
- What are the benefits of working in partnership for Maria, John and Billy and also for you, the access worker?

Week 2

The following week you ring Maria to discuss the upcoming access. You ask Maria if she would like to prepare an activity for the children to engage in. Maria does not respond. You suggest some age-appropriate games and activities. However, Maria appears annoyed by each suggestion, stating they would not work with her children and that her children would not enjoy them.

- What do you feel has caused Maria's annoyance?
- How can you support Maria's autonomy as a parent?
- Reflect on why parents whose children are in care may be reluctant to take on board suggestions and support offered by the social care worker and other professionals.
- Suggest how you as a social care worker can build a partnership with Maria to ensure Maria and her children enjoy quality time together at each access.

Case Study 2

Kate

Kate has four children who are in foster care. You are briefed by the social worker on the case and advised that Kate can be inconsistent in her contact with the children. Therefore, the social worker feels it would be best if you made contact with Kate a number of times in the days preceding the access to ensure Kate has transport to and from the access and is aware of the time, duration and location. Access is arranged; however, Kate cancels on the morning of the access. Access is rearranged but Kate once again cancels due to illness. You speak with Kate and are assured by her that she has everything organised for a newly rescheduled access. You ring the foster parents and communicate the new arrangements. Kate is getting public transport, so you ring on the morning of access to confirm she is on the train. Kate confirms she is on her way and will arrive 20 minutes before access. You confirm the arrangements with the foster parents, assuring them that Kate is on her way. The foster parents and Kate's four children will have an hour-long journey to access and advise you that they will be leaving earlier to ensure the children have lunch before they meet with Kate. You are en route to the access when your phone rings and Kate advises that she boarded the wrong train and is now stranded with no connecting train to bring her to access on time. Kate states that she has forgotten her purse and that the next connecting train is later in the day. Kate is very upset at the possibility that she will not see the children and requests that the time of access is changed to later in the day. You are conscious that the foster parents and children are already en route but also that the social worker really needs this access to go ahead so that the children can spend time with Kate. You will be driving past the train station where Kate waits at the train station.

- Do you cancel access?
- What are the implications of doing so?
- Is there an alternative option?
- What are the implications of the alternative option?
- Can you see the need to work in partnership with Kate in order to ensure the children have regular and rewarding contact with her?
- Is there a need to work in partnership with the social worker also?

Kate's case is a reminder of the very thin line between empowerment and enablement!

The social care worker has to make a quick decision: either cancel the access, resulting in more disappointment for the children, another wasted journey for the foster parents and a parent who you know would benefit from seeing her children; *or* discuss with the social worker and arrange to pick Kate up and bring her to access.

TASK 3

Discuss the following questions:

What choice would you make?

Is this choice enabling or empowering Kate?

What factors do you take into consideration?

How can you support and work in partnership with Kate to ensure this does not happen again?

Case Study 3

Case Study 3: Michael

Michael is 16 years old. He has recently been placed in an adolescent residential unit. Michael was initially placed in relative foster care; however, after a short time this placement broke down due to Michael's challenging behaviour which included self-harm, substance misuse and overtly sexualised behaviour. You are asked to undertake direct work with Michael in order to support the achievement of Michael's personal goals, which include a desire to gain part-time employment. You know that in order to do so, Michael will require support to express his emotions in a positive way. You have studied Michael's case file and feel that all interventions to date have focused on the challenging behaviour and have not explored the underlying reasons for the behaviours that challenge.

- Is there a need to work in partnership with Michael as part of his care planning?
- How can a partnership between Michael and the social care worker support Michael to find alternative positive ways to express emotions?
- In developing interventions to best meet Michael's needs and help him achieve his goals, is a partnership with other professionals important? Why?
- Is there a need for the case worker to work in partnership with other professionals and services in order to best support Michael?

Power and Authority

Social care work involves supporting service users, parents and families during times of need when emotions run high. The family, according to Clarke Orohoe (2014: 76) may feel powerless and unheard in interactions with support services. Research conducted by Gilligan (2019: 224-5) on foster care in Ireland reports that *'for some parents there seems to be a general sense of losing influence or status'* plus a sense of exclusion from the child's life heightened by 'the lack of information they receive about what is happening in their children's lives'. Social care work with children and young people in care and aftercare as described in Case Studies 1 and 2, highlights the power imbalance that some service users and parents/carers may find challenging. This negative perception of who holds the power or authority can also result in challenges for the social care worker who hopes to develop a partnership with the service user or parent. The involvement of service users, parents and carers in decision-making and care planning can provide for the sharing of power, thus promoting better outcomes. Person-centred planning respects the rights, feelings, thoughts and wishes of service users. This partnership approach to care planning empowers the service user, parents and family to participate meaningfully in decision-making and planning.

This proficiency raises the student's awareness of power and authority dynamics in social care practice and encourages the development of a self-awareness regarding power in relationships with service users. The student is also encouraged to use the case studies to reflect on the ways in which a perception of power can negatively influence partnerships and how a partnership approach can alleviate negative perceptions of who holds the power or authority in the relationship.

Tips for Practice Educators

This proficiency enables students to understand the need for and importance of working in partnership with service users, carers and other professionals.

1. ***Help students to apply theory to practice.*** Lalor and Share (2013) advise us that social care workers require a *'thorough knowledge of procedures, policies and legislation'* and that it is this *'theory base that gives them an understanding of people, systems and practices'*. This theory base is achieved through study and examinations. However, this proficiency requires more than theory, aiming to support a practical understanding as to why a partnership benefits service users, parents/carers and professionals.
2. ***Focus on skills of partnership work.*** Explore in supervision what skills and qualities the social care worker must possess in order to develop partnerships and why a partnership approach to care planning is essential.
3. ***Design service-specific case studies.*** Interactive case studies can be utilised to encourage the student to explore and reflect on different areas of social care practice, and examine the need for and types of partnership in each area. The student can then relate theory to practice. Case studies can be supported by gaining the insight of other professionals or services on their partnership with the social care worker in a range of social care settings. This insight can demonstrate to the student just how important the partnership between the social care worker and the relevant other professional is and how the partnership can support the development of person-centred care planning and interventions to meet the needs of service users. Guest speakers can also increase the student's awareness of the ways in which different services work in partnership with social care workers.

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Chapter 36 – Des Mooney

Domain 2 Standard of Proficiency 13

Understand the need to build and sustain professional relationships as both an independent practitioner and collaboratively as a member of a team.

KEY TERMS

Professional relationship as a process

Impact of professional on personal

Supporting roles of relationships

Social Care Workers are professional practitioners engaged in the practice of social care work. Social care work is a relationship based approach to the purposeful planning and provision of care, protection, psychosocial support and advocacy in partnership with vulnerable individuals and groups who experience marginalisation, disadvantage or special needs. Principles of social justice and human rights are central to the practice of Social Care Workers' (SCWRB 2017).

Introduction

This chapter sets out to explore the theme of professional relationships in social care practice. As professionals we do need to be mindful that at times there can be a blurring or misunderstanding of relationships in the workplace. Using the themes relationships as process, integration of theory to practice, communication, power, supports and teams, this chapter will explore some of the complexities involved in our work. While we work with the most vulnerable in society, we need to be mindful of the impact of this work on our professional relationships. Using a case study, the chapter will explore how difficulties in one area did impact on other areas. We will also look at how, through good communication and supports, relationships were strengthened with better outcomes for all involved.

Professional Relationship as a Process

Given that much of our work is driven by relationship-based practices it is incumbent on us to understand that how we act and react, our use of language and manner, and our actual practice, both with our colleagues and our clients, is very important. The bonds of trust between service users and social care workers are tenuous at the best of times and one false word or deed can significantly impair a previously positive working relationship.

We need to be mindful throughout our work that we understand the world and our experiences in a different way from many of our service users. The idea of trust has been shattered for many of them, so that any action or word can be interpreted differently from what was intended. As we form a professional relationship with a service user, we explore the ways in which the service user communicates and responds to messages. We work within the parameters of their understanding, not ours. We need to be kind and careful. It is important that when we impart information the service users completely understand what we are communicating. This could be important information relating to their care or placement; or it could be a joke. How we relate to our service users, our tone and body language are equally important.

Case Study 1

Blossom

A social care practitioner and student, Blossom (not her real name), approached me last year and wanted to talk. She explained she had been suspended from her full-time job for two weeks because a service user, Judy (not her real name), had made a complaint about her to the management of the agency she was working in. The agency has residential and day care settings for individuals with a range of intellectual disabilities. Blossom was upset and tearful and could not make any sense of what had happened. Blossom spoke about having a good 'relationship' with Judy, of 'getting on great', of being 'friendly' with her, of 'having a laugh', and of some of the work she engaged in with Judy. This work involved supporting Judy with daily tasks such as going to the shops, understanding and filling out forms, some personal tasks, and, playing games and talking. One of their routines was to go for a cup of tea each time Blossom was on shift. Judy was said to have looked forward to this.

I noticed immediately that Blossom regarded Judy as something of a friend and was proud of the work she had done with Judy. When I asked what led to the suspension, she explained that in the course of a conversation with Judy she had referred to her as a 'wagon'. She stressed that she was only joking and that within the relationship Judy should have understood what she had meant. Judy had become very upset by this comment and had subsequently made a complaint. The result of this complaint was that Blossom was suspended for two weeks and had to make reparation with Judy. She had returned to work but realised that 'it wasn't the same'.

I spoke to Blossom about how I felt she had made an error, that she had thought she was in a 'friend' relationship with Judy, where loose language could be tolerated, that her boundaries were skewed, that the mantra 'friendly not friend' was absent, that, while being friendly, the social care practitioner had to maintain a professional relationship with the service user at all times – not sometimes. I asked Blossom did she think she was going to be sitting at home, PJs on, glass of wine in hand, watching *Ant and Dec's Saturday Night Takeaway* with Judy? Blossom replied with horror, 'Of course not.' I replied, 'Why, then, did you speak to her like she was one of your mates?' We spoke for a time about whose needs were getting met by the dynamic within the social care practitioner/service user relationship. We also talked for a while about how Blossom imagined Judy saw the relationship. Blossom thought about this for some time and then spoke of Judy really looking forward to 'me coming in'; of Judy smiling and waving when she entered the building and of Judy getting very upset when Blossom greeted someone else before she greeted Judy. I asked Blossom what they talked about. Blossom responded 'everything', but could not be specific about anything they had talked about.

Integration of Theory with Practice

Laura Steckley writes of students and practitioners of social care struggling to meaningfully integrate theory and practice 'with concerning gaps between what is being espoused in the literature and what happens in the field' (2020: 2). Phelan in Steckley (2020) notes 'the immobilising sensory overload experienced by students on placement and newly qualified practitioners', describing how they instead turn to '"common sense" explanations and approaches' (2000: 2); of a sense among some students that theory is a university requirement rather than an aid to practice. 'This lack of integration or even rejection of a theoretically informed basis for understanding and decision making has concerning consequences – not only for the development of the workforce, but for the care experiences and outcomes of children and young people' (2000: 2). While Blossom understood the importance of

maintaining a relating approach in her relationship with Judy she had not adequately reflected on what was in fact taking place. The 'immobilising sensory overload' Phelan notes is a very common place for students and people new to social care. At times they are fooled into thinking that what we do is simple, when in fact they are not quite grasping what is taking place. At other times it can be overwhelming.

Cameron notes the difficulty in breaking down communication into a skill set and of producing meaningful criteria for assessing its quality, while also noting how safe and appropriate practice to service users has a moral and ideological dimension. 'Therefore, it is important to give trainees the opportunity to discuss – and reflect critically upon – the beliefs and values that underpin judgements on communication in care settings. If they are presented as simply common sense, there is no way to resolve the problems and contradictions which may arise in real world situations' (2004: 71). The ability to reflect upon practice through positive working relationships, supervision and other supports gives us practitioners the opportunity to unravel the complicated messages we are experiencing all the time. Over time it became clear that Blossom was not reflecting on her relationship with Judy, rather was taking a ill-considered common sense approach and not thinking in a deeper way about how one dynamic might support another and how these in turn might reflect in better outcomes for Judy. The cup of tea remained 'just' a cup of tea and not an opportunity.

Power within the Professional Setting

Grainger notes power differences: carers, though themselves not a powerful group, presenting 'their own definition of reality as more valid than that of a confused elderly patient' (1998: 54); carers entering into patients' 'confused fantasies' 'because this made it easier to secure co-operation with routines' (1998: 55). Seden notes the importance of communication; of a process involving thoughts, feelings, ideas and hopes being exchanged between people. Seden also notes how important it is to respect the values and beliefs of others and for carers to be consistent in their professional authority and function. 'Meanings must be checked carefully, and in each exchange, care needs to be taken to be aware of, and reduce, the blocks to communication that can come from the many differences between individuals, such as authority and power, language, ability and disability, personality, background, gender, health, age, race, class' (2004: 214).

Clearly Blossom needed to be more aware of what she was saying and how it might be understood by the service user, and, of the power dynamic on display. On the face of it there were two people sharing a cup of tea. Judy clearly enjoyed her afternoon tea with Blossom. It appeared to me that Judy was in control of the relationship and understood that Blossom, a staff member, took her out for a treat every time she came in; while Blossom appeared to think something else, that she was engaging in important work with a client (she was, actually) and that this in some way involved befriending her. Sometimes you don't have to chase the work; it is right in front of you and you don't have to tamper with it. If Blossom had done nothing at all maybe Judy would have enjoyed their time together more. By being overfriendly with Judy, Blossom made Judy feel uncomfortable; so uncomfortable that she made a complaint. The relationship already existed between social care practitioner and service user.

It was evident that Blossom had been engaged in some good work with Judy, and she definitely thought she was doing good work. Perhaps when Blossom made the remark Judy sensed a change in the power dynamic; from one where she was comfortable to one where Blossom was 'in charge'. This prevented the relationship from progressing to one where practical social care issues could be addressed. It is often said by social care workers, 'I get lots of work done in my car.' I take this to mean a situation where a social care worker and their key person (for example) share a journey where gentle conversation, space, time and lack of intrusion from others allows firmer foundations to be created for stronger relationships, trust to be built and further work to take place.

Case Study (continued)

Blossom was Initially irritated by my comments, but we began to talk about relationships in work in general. Blossom was not getting regular supervision, she had 'good, not great' relationships within the wider staff team and had felt marginalised by the team at times. In addition, Blossom felt she was learning nothing while working in this agency. I spoke to Blossom about the links between college learning and workplace practice and noted that her application to boundaries and actual simple things was troubling. The most troubling aspect was when Blossom explained to me that she fully understood what I was saying but this had not been explained to her in her workplace. While Blossom was punished for referring to a service user as a 'wagon' the incident was explored at surface level only and little learning had taken place.

It was interesting to note that Blossom seemed to think that the service user/client was her friend, while at the same time stating that she had no real friends or people to talk to on the staff team. Perhaps Blossom's relationship with Judy was in some way compensating for her lack of relationships within the wider staff group. This matter was further conflicted by Blossom having no avenue to discuss such inconsistencies through informal talk or regular supervision. Blossom continued to shield herself through the belief that she was engaging in powerful work and was demonstrating good relationships while in fact doing the complete opposite.

The Dance (Part 1)

Some might argue that Blossom was lucky to keep her job, that she had made a big mistake. However, on reflection and in conversation it became clear that the agency had some responsibility in this matter also. The concept of a team doing a 'dance', perfectly in step, where said and unsaid are understood, where higher thinking practices are normal, and empathy, listening, understanding others, the ability to wait and kindness are the norm is one I hear about in social care circles. Krueger writes, 'like modern dancers, competent workers study, practice, and develop the knowledge and skills that allow them to be in their experiences with youth in the most effective and responsive way. These workers sense, as well as know, when to intervene or not intervene, move close or farther apart, raise or lower their voices, and increase or slow the pace' (2005: 22). Krueger also stresses the importance of relationships when promoting development. In his 2005 study of youth work as a contextual, interpersonal process of human interaction, Krueger identified four main themes – presence, rhythmic interaction, meaning making and atmosphere – as contributing not just to positive relationships but also to the development of appropriate interventions.

Myer (2017) writes of social carers having varying levels of knowledge and experience within the social care system. It is a combination of experience, knowledge, maturity of personal and academic qualities and an ability to critically reflect, and self-reflect, that supports this social care 'dance' that we do. But significantly it is about relationships, understanding the difference between personal and professional relationships, and being willing to explore and reflect and change attitudes where necessary. Lalor (2013) writes of the quality of the practice environment, training, professional supervision, the philosophy of one's peers, the ability to self-reflect, the ability to turn criticism into best practice, research and advocacy as ways in which a social care practitioner develops. All of these are done in the context of relationships.

One of the biggest learning curves a social care practitioner makes is when the concept of professional working relationship is ingrained into their practice. This, however, is a process. If I am asked how I would explain social care practice, my response is that it is all about relationships. Without positive working relationships, the work we do is stymied by miscommunication, suspicion, stress and weariness, by functions and form, by judgement and fault finding. It is not that the job doesn't get done, it is just that it is exhausting, and no joy is gained from it. And it is where bad practice occurs. There is quite a blend of personal and professional relationships in social care, especially given the amount of time we work together and the sometimes stressful nature of the work. With positive working relationships the atmosphere is better, more creative, there is more sharing of information and ideas, people support each other and are honest with each other. Criticism is turned into better practice rather than personal offence and natural learning opportunities are rife. And people are kinder to each other.

Supporting Relationships in Practice

As a social care practitioner, I have my 'go to' people when I need advice. These are people who will tell me when I mess up and offer honesty and care. They will also support me at times of stress and worry. And they will celebrate with me when appropriate. This is important.

Three significant things happened when I started as a social care practitioner. One was that I had regular supervision from the time I started. This immediately meant I had a relationship in work even if I did not understand much about it. My supervisor did, thankfully, and over time I came to understand the value of reflecting on practice and acknowledging areas of learning. This includes making relationships with other staff members, making relationships with the young people in my care, the links between the staff team and the collective multi-disciplinary network and the macro/micro system of relationships that occur within this. I listened to the way people spoke to each other and to the people in our care. I watched as people created structured and boundaried environments for our young people to act out their own relationships with their world. I took risks and it worked, or it didn't, and I brought this back to supervision and discussed the hows and whys. I watched how people work. I saw how different approaches work with different people. I watched as people displayed great bravery and no little honesty and yet at the same time they did not dominate situations, leaving room for the young person in our care to express themselves, and not be overloaded. And I talked about this in supervision. I watched as a group of 15 people, different personalities, with different approaches to the work, some loud, some quiet, some sporty, others artistic, some unassuming, others a 'force', action men, admin angels, kitchen devils, specialists, comedians, therapists, provocateurs, slackers and completists, all seemed to gather together under an umbrella of care and single-minded ambition; to try to make the tomorrow better than the yesterday for the people in our care. And I talked about where I might fit into this brilliant human machine.

I began to make relationships within the wider staff team. With some people you would be up until the wee hours talking about everything, not just work; with others it was function, get the job done, it's late, time for bed. Some people came in with a 'bag of tricks' in the form of ideas, or activities, and sometimes I wondered if I would ever get a look in; other times I was glad because the 'bag of tricks' was so full of good stuff. Some were real talkers and I found out a lot about people's families or relationships; others were full of questions and, depending on the friendship or mood I was in, I would tell all about myself. Some were funny, others were brilliant at getting you to say what was true, about yourself and others.

Some challenged my practice. This was uncomfortable but it was honest. Over time I understood that this was part of 'the process'. That we weren't going to get the job done by being nice all the time. This created fractures and at times there were tears and upset, and sometimes I took this terribly

personally. Over time I realised that to challenge someone's practice appropriately is a good way to help them to learn, reflect and shape their practice when necessary, to meet the demands of the task. Through experience and watching and listening and getting braver I learned more about controlled emotional involvement, theories of practice, listening, responding, sharing and recording information and workloads, and the importance of the team. I learned not to be afraid to look at myself. We ask so much of our service users. In some ways we have to 'go to the well' ourselves at times. When these difficult times occurred I still had other relationships within the team where I could discuss my dilemma. And when the learning was done we regrouped and moved forward. And I am more than willing to have my practice questioned and more than willing to question others'. The goal is the best care for the people in our charge.

I also began to make relationships with the people I worked with, in my case a group of teenagers in residential care. One was leaving soon, wanted nothing to do with the 'new' person. Her time was up. Making a new relationship just might have been too painful, or maybe she just wasn't interested. Our relationship was one of respect, but I can't say I got to know her well at all. Another 'toyed' with me; they were there a while also and knew how to play new staff; nowadays I look at how the young people look at new staff when they first meet them, what do they have in store for them? And will they survive? Two other young people were curious, and I began to get to know them. Between play, shared experiences, events, accidents, incidents, talking and listening, and time, relationships formed.

The next step was key-working a young person, being their advocate at meetings with the multi-disciplinary team, at reviews, listening to their ideas about how they wanted to be, making sense of challenging behaviours, empathising and being part of their holding environment. A very significant professional relationship but one with huge personal investment. The very fact that you know every detail about a young person you are key-working is in itself a personal investment. Trying to support them as they come to terms with their past, present and future can have quite an impact on the person. This is the place where wider team relationships become crucial, where the support network, both silent and obvious, becomes essential. Some moments become easier to understand, others become more bearable, when shared. Since then there have been many kids who have come and gone. We remember every one of the young people who pass through our door and we celebrate them and thank them for the collective learning they have bestowed on us.

Learning from Experience

The first thing that irked me when I spoke to Blossom was that she reported that supervision was not happening regularly. Proper and regular supervision with an experienced supervisor will support better practice and also identify many of the issues Blossom was presenting with: lack of boundaries; thinking that she needed to be a friend to the service user; the fact that she felt on some level that she was working alone; and the fact that her relationships within the team in general were not great. In addition, proper supervision would have enabled Blossom to form a professional relationship with her supervisor where good practice would be discussed and encouraged. That Blossom spoke of 'not great' relationships with the wider staff team also concerned me. Social care practitioners speak about 'a lonely place' where work is difficult and suspicion abounds, where mistakes are pounced on and good work overlooked, and where relationships within the team are at a low. These are among the toughest times in our working life.

In my role as Blossom's college supervisor I made contact with Blossom's employer and arranged a meeting. At this meeting a number of issues were discussed. The issue of supervision was resolved and Blossom now has supervision once every two weeks. It was explained to me that because the unit was so busy it was not possible to provide regular supervision up to this point. Blossom was also appointed a mentor and an arrangement was made where Blossom would fulfill a number of learning

tasks each week and these would be monitored. Blossom would also attend team meetings regularly and would be invited to/included in any training or events the unit would be having. I would also check on how Blossom was doing more often with both Blossom and her employer/supervisor. Much more structure and detail supported Blossom's understanding of the experience, even though it increased the workload considerably. I also spoke with Blossom about how she could improve relationships within the wider staff team. Very often it just takes time for a team to get used to a new member; at other times a new staff member must look at what they are bringing to the collective and see where that fits in.

Blossom is happier at work, is still making mistakes, but nowadays she is learning from them rather than being punished and not knowing why. She is also engaging in good social care practice and this is being acknowledged, and the learning is being recorded and noted. Blossom has also made strides in her relationships with the wider team and has developed a good working relationship with her mentor. In addition, Blossom has attended meetings and training days with the team and noted how beneficial they have been to her development as a team member. She jokes about the shared 'horror' of role plays at these events and the fun and engagement, as well as the learning. I have encouraged Blossom to contribute to the meetings she is attending and to listen to the way others manage themselves at these meetings. Blossom asks more questions and reads more. She is engaged in a supportive role in many projects the unit is involved in. These include links between the local community and the unit, social skills, COVID-19 awareness, art, and 'dance' classes. Blossom also has developed much better relationships with the service users and when she talks it is now with a much deeper understanding of boundaries and the nature of care. Blossom also has a much better understanding of her relationship with Judy, although for the time being they are not working together on their own.

The need for us to build and nurture relationships within a team is very important and is in my opinion a key component in working independently with service users. Blossom has now got a place to go where she can discuss the dynamic between herself and the service users in her care and an opportunity to regularly explore the finer points of practical work with vulnerable people. Blossom also has the opportunity to talk about the way work is impacting on her life.

Conclusion

This chapter invites us to look at professional relationships under the gaze of the Standards of Proficiency – Domain 2 Proficiency 13; 'Understand the need to build and sustain professional relationships as both an independent practitioner and collaboratively as a member of a team'. It sets out a scenario where Blossom's inexperience, allied to an absence of good enough relationships within the staff team, leads to a situation where bad practice was evidenced. This proficiency acknowledges the significance of building and sustaining relationships in social care. This chapter outlines how we can do this in practice; through positive workplace relationships, effective supervision, mentoring of new staff, of an atmosphere where practice is discussed, ideas are floated and decisions are not made without consultation, where we watch for good practice from people, where we watch different styles of communication, and where we only do the work we are ready to do. Now that Blossom is more integrated into the wider team she can accompany others and work collaboratively and effectively. Soon Blossom will begin to work independently of others, while maintaining her team ethos and supports. This way Blossom's potential is checked, and celebrated, her current learning is acknowledged, and further learning identified. Blossom now has a much better understanding of the role of the team and consequently has made significant progress in learning their particular 'dance'. It is going to take time. But it does take time to learn new moves.

The Dance (Part 2)

Some day, very soon in fact, Blossom will walk into a room and in an instant understand the 'temperature', and she will know how to respond to it. She will move at a pace that interrupts no one, she will feel no less and no more important than anyone in the room, she will listen and watch for cues, she will 'hold' herself, and she will wait, and then she will go to work.

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Chapter 37 – Gráinne Powell

Domain 2 Standard of Proficiency 14

Understand the role and impact of effective interdisciplinary team working in meeting service user needs and be able to effectively contribute to decision-making within the team setting.

KEY TERMS

Interdisciplinary teams

An interdisciplinary response

Ingredients for success

Social care is … a worthwhile and fulfilling profession, filled with possibilities. The social care profession thrives on innovation and creativity. It is ever evolving. The cornerstones of social care are empathy and commitment. It's a profession that is built on relationships and a therapeutic environment.

An interdisciplinary team in social care is a collection of people from different disciplines who come together with a shared goalnand vision to benefit the service user.

Intradisciplinary: Single discipline working as a team

Multidisciplinary: Staff from different disciplines working together, each member representing their own discipline and bringing their professional knowledge and expertise to the team. Generally creating discipline specific care plans.

Interdisciplinary: An integrated approach to working, sharing, resources and learning from the expertise within and across the team. Sharing responsibility and making joint decisions.

Interdisciplinary Teams

Interdisciplinary teamwork is a common practice across the social care settings. It involves different types of staff working together to share their skills, expertise and knowledge. Working in interdisciplinary teams gives service providers the ability to pool their resources and provide a holistic package of supports to service users. Terms such as intradisciplinary, interdisciplinary and multidisciplinary are used interchangeably to describe collaborative team working. However, there are some distinct differences. Inter/multidisciplinary teams are generally broader than intradisciplinary teams and involve staff from different professional backgrounds working together. Other teams in the social care area are made up of staff from single disciplines working in an integrated way using open communication to share ideas and make decisions.

An Interdisciplinary Response

The issues that impact on the lives of families and communities are often complex and varied. The uniqueness of individuals and the impact of their circumstances must be accounted for when responding to them. This often requires a myriad of approaches and resources to meet specific needs. No one agency or discipline has all the expertise and resources to meet the needs of the individuals we work with. While upholding the ethics and integrity of our agency, we strive to blend a response for the greater good of the service user. However, success does not 'just happen' because services pull together. It is usually the result of a substantive investment of skills, resources and time to ensure that all members of the team work well together. By pooling our resources and providing a holistic and integrated response, we can do so much more that we can on our own.

Lalor and Share (2013) describe how the social care profession is ultimately concerned with the delivery of high-quality professional care to adults and/or children with health and social care needs. The underpinning principles that guide us in our work in social care, such as building respectful client interactions, help us to listen more deeply and understand more compassionately when advocating for and on behalf of others. A core aim in social care is to empower individuals to develop the resources required to overcome adversity in their lives. This special emphasis on the capacities of individuals in meeting their own social care needs frames how the social care worker highlights and addresses needs within the interdisciplinary team. Focusing on strengths and resources and empowering service users to access their internal supports builds self-belief and strengthens coping mechanisms. The worker and the service user work in unison to address concerns and seek out solutions that will meet real needs.

All members of interdisciplinary teams are selected on the basis of their relationship with the service user. Social care practitioners play a very valuable role on interdisciplinary teams due to the 'hands on' nature of the work. Social care practitioners work alongside service users in a non-judgemental way that gently supports growth and development. Our role with service users is to offer care and support in a safe, trusting environment. The empathy and understanding that is fostered in social care relationships means that the social care worker gains an insightful knowledge of service users that many other professionals at the interdisciplinary table may not have. This knowledge, based on respectful everyday interactions, strengthens solutions by placing a practical, person-centred lens on them. So never underestimate the value of the social care practitioner's contribution to the interdisciplinary team. It is rich in insight and offers a fresh relational approach to meeting the real needs of families and communities.

Ingredients for Success

The functionality of any group depends on a having a few important things in place. Because the interdisciplinary group embraces a collection of people from different backgrounds, there may be conflicting organisational cultures, agendas and values. Working towards a shared goal requires compromise and setting aside organisational differences. Having terms of reference and guidelines in place can prevent conflict and ensure that goals are met. Every group needs a well-defined purpose. This gives clarity and focus so that everyone involved knows what is expected of them as a team member, and what success would look like. Good leadership, along with clear roles and responsibilities, will also make the team more efficient and focused. Having committed members who want the best outcome for all involved is a crucial marker for success, as it propels the group to think outside the box, to be creative, insightful and flexible in seeking the best solutions.

Purpose

Any interdisciplinary team must have a clear purpose. All too often, groups and teams are formed without a clear purpose, which can lead to feelings of frustration at their lack of direction and progress. It can also make members of the team feel insecure and unsure about their role on the team and doubt the value of the group. The purpose of the team should be clearly outlined and some measures for success should be noted from the onset so that progress and achievements can be monitored and evaluated on an ongoing basis.

Reflection

Think of a group, team or committee you have been involved with. It could be a sports team, a school committee, maybe even an event or party planning group. Think about these questions:

- What was the purpose of the group?
- What helped get things done?
- What strategies were used to keep everyone focused?
- What didn't work well?
- What would you do differently?

Leadership

Leadership in interdisciplinary teams keeps the momentum and integrity of the group in place. It adds structure to the team by ensuring that timeframes are met and decisions are made. Strong leadership will strengthen interdisciplinary team working by encouraging equal participation in the process. It should drive the team forward to overcome barriers, to build connections and to seek out success.

Roles: Respect and Understanding

It's not always easy to work together, especially when the values and expectations of organisations are so varied. However, if respect is expected from the outset and if there is an understanding of how other agencies operate, a way forward can be achieved in the best interest of service users. This appreciation for other styles and approaches to supporting individuals will make the information-sharing and decision-making processes more fluid and genuine. A successful interdisciplinary group is one where the individuals are valued equally for their insights and contributions. Less experienced members should be given opportunities to ask questions in the team. This often brings fresh perspectives and learning for all team members. Working together to achieve a shared agenda requires actively listening to colleagues so that opinions and thoughts are heard and mutually respected. Successful teams build on the strengths of each individual member.

Flexibility

Interdisciplinary teams need to have an element of flexibility to get things done. When working with people and for people we must be mindful that people react differently to the same situations, change is difficult, need is complex and one size does not fit all. With all this in mind, meeting the needs of service users requires a flexible approach and a collective response.

Commitment

Working together can be challenging, but a committed team who are working towards a shared goal will make the process more focused and productive. Committed team members will take their responsibility more seriously; they will follow up on issues and will work to find solutions to overcome barriers and obstacles. It's important to reflect on the motivation behind interdisciplinary teams and to think about the most desirable outcomes and practical steps needed to achieve them.

Language

Language is very important in social care and we need to be mindful of how our language is received by others. All agencies and services use terminology familiar to their own disciplines. The language we use every day with our peers becomes familiar and comfortable to us; however, it may not be widely understood outside our own circles. When we work collaboratively it's important to explore and discuss the different terminologies and interpretation attached to them across services. It is then useful to agree and outline the terms to be used for the purpose of the team.

Personal Reflection

Having spent most of my career in the health service, I am extremely conscious of how easy it is to fall into the 'language trap'. The use of abbreviations and terminology that are not widely familiar outside your organisation can alienate interdisciplinary partners. I have found from my experience in delivering training, facilitating groups and participating in interdisciplinary teams that the more relational and plain I keep my language, the more tuned-in people are. We don't need to embellish our points or use jargon. Be present, be clear and ask for clarity if you don't understand something. Someone else will probably be relieved that you asked! Setting a tone of inclusivity and clarity is essential for good communication in interdisciplinary teams.

Collaboration

It will not always be possible for a single agency or individual to bring about change. Time is spent during the initiating phase of an interdisciplinary team in agreeing who needs to be involved. This decision is based on previous connections to the service user and possible new sources of support that may be beneficial. Then, the process of deciding what needs to be done, how it needs to be done and when it needs to be done can take place in a collaborative and inclusive way to maximise impact and outcomes. Interdisciplinary teams rely on service providers and service users working together as a collaborative team to set goals. Sharing responsibility across the team while also respecting the individual team members' autonomy and expertise will generate a collaborate approach to supporting service users.

Interdisciplinary Teams

Benefits of an Interdisciplinary Approach

The benefits of interdisciplinary teamwork are substantial for service providers and service users. They have the ability to improve the overall effectiveness of services provided to children and families in the community. They can enhance the services offered by improving work practices and creating a one-stop shop for sharing expertise, exchanging ideas and pooling resources. The generation of creative ideas and alternative perspectives can inspire new methodologies for managing complex issues. Interdisciplinary teamwork prevents the duplication of services and assessments by bringing together the key people involved in the lives of service users to give their input to plans and make decisions.

Regular meetings can also improve the relationships and communication between different disciplines. This leads to higher levels of innovation and a joined-up approach to care. Many times in the past, service users sadly fell through the net and were not protected due to a lack of co-ordination and communication between the people involved in their lives. If services talk to each other, share resources and think how they can jointly support service users, time can be saved and more robust, sustainable outcomes can be achieved.

TOP TIPS FOR ENGAGING IN INTERDISCIPLINARY TEAMS
Ask for clarification on the purpose of the meeting.
Learn about the terms of reference, decision-making processes and the general running of the group.
Be prepared. Arrive on time, read over notes and minutes and have your paperwork organised.
Know what your service can contribute and what the limitations are.
Be comfortable and content in your appearance.
Express your views and be assertive in making your points.
Keep an open mind and listen to the opinions and suggestions of others.
Be clear and concise in your communication.
Make connections, try to get to know other members of the team. Peer support is an invaluable asset in social care.
Be confident in your ability to bring solutions and offer insight.
Ensure an agreed framework for evaluating and reviewing the team purpose and productivity.
Use supervision sessions to reflect on your personal progress and seek out new ways to be more effective.

Questions to consider.....

What does the social care practitioner bring to the interdisciplinary team?

What, do you think, are the barriers to interdisciplinary team working?

How can these barriers be overcome?

Tips for Practice Educators

This proficiency will require students to have an understanding of how to engage and participate in interdisciplinary teams. It is important that the student is afforded the space to reflect on what makes teams successful and the value of the social care contribution. Time spent unpacking interdisciplinary team success and the drivers of success as it relates to the service will develop the students' understanding of interdisciplinary teamworking in a very real and tangible way. The practical aspects of participation and engagement, such as preparation and presentation, should be discussed as they are modelled though the placement. It's important that the student is exposed to the level of preparation, the attention to relationships and the follow-up required in interdisciplinary teamwork. The finely tuned professional will often make the work look effortless and seamless, so getting students involved in preparation and collaboration before and after will be extremely useful. Encouraging the student to link actions to policy and theory will also help them to place the actions in context. Sharing agency reports and guiding national/international documents with the student will strengthen their learning for future practice.

Taking part in meetings generally will provide the student with the opportunity to view different perspectives from services and families. It will also give the student the invaluable opportunity to practise with the support of a supervisor in a safe environment, to articulate responses and to receive critical feedback. It may not always be appropriate for the student to actively participate in interdisciplinary team meetings; however, time spent reflecting and documenting what went well, how decisions were made and what outcomes were achieved will help the student to focus on the skills and techniques involved. Assigning practical tasks pertaining to the set-up of meetings and follow-up with services and families will increase the student's participation in the dynamic of collaborative teamwork. A practical and solid piece of work for the student could involve the collation of a community needs assessment to gain insight into the workings of the different disciplines involved in the lives of families and communities. In exploring and examining the needs of communities, the allocation and co-ordination of resources will be better understood.

Students often have fresh and enlightened perspectives on the complexities of social care circumstances. Giving the student the opportunity to share their thoughts and creativity while encouraging them to shape these ideas in light of the community circumstances, resources, services and guiding documents will focus their application of theory to practice. Feedback and the use of reflective practice will help the student to sharpen their preparedness and their expertise through active participation and reflection. Asking the student to consider their strengths and the challenges they encounter, in relation to working as part of a team in their everyday life, combined with their practice experience, will help them to identify progression pathways.

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Chapter 38 – Des Mooney

Domain 2 Standard of Proficiency 15

Understand the role of relationships with professional colleagues and other workers in service delivery and the need to create professional relationships based on mutual respect and trust.

KEY TERMS

Professional relationship

Respect

Empathy

Labour of love

Social care is … when I am asked what social care is I tend to give the same answer again and again. It is about relationships.

Professional Relationship – Lexi's Story

This chapter uses a case study (Lexi's story) to discuss the role of relationships with professional colleagues and other workers in service delivery, noting the various relationships Lexi has in her life now, and how the dynamics between these impact on Lexi's life. The chapter makes the argument that the relationships we have with service users are also a measure of the type of relationships we are looking for us as professionals and how respect, empathy, love, accountability, teamwork, integrity, organisation, nurture, self-regulation, harmony, initiative, and partnerships are enacted in our professional lives.

Interdisciplinary and *multi-disciplinary* are terms used to describe the links between the various professionals involved in people's lives and the roles they play. Interdisciplinary teamwork involves a number of people across a staff team sharing their skills, knowledge and expertise, with a common purpose; to set goals and boundaries, make decisions, share resources and responsibilities. The multi-disciplinary *inter-agency* team approach to care refers to the significance of how agencies and individuals communicate with each other; and how mutual trust, respect and professional responsibility can lead not only to a creative working environment but much better outcomes for service users. One definition offered by Linden (2002: 7) states, 'interagency collaboration occurs when people from different organizations produce something through joint effort, resources, and decision making, and share ownership of the final product or service.' This collaboration refers to family caseworkers, social workers and social care workers, mental health providers, teachers, support workers, policy-makers, managers and legal experts. The team members focus on specific areas of care and these in turn are brought together in the form of an overall care package or plan. Linden further notes that better understanding by each member of the multi-disciplinary team of the others' roles in the case, of their actions and perspectives, will only lead to better outcomes for the service users.

Respect

This chapter uses a case study to look at professional relationships, and how actions in one area impact on others. Throughout this chapter we will be reminded of Lexi and how people like her are affected directly by our actions and decisions. When you look at Lexi's story, think of the many and complicated relationships she has through many disciplines, and how sensitivity, communication, kindness and honesty are essential to helping her realise her true potential.

Case Study 1

Lexi

Lexi is amazing. She is funny, kind, thoughtful, full of surprises, is helpful and has a keen memory. She is a great singer and loves praise. She will ask you how you are. She is interested in your life. She doesn't like questions about her life though, and always says things are 'good' or 'I don't know' when asked even the simplest question. She is also angry, depressive, inconsistent with the truth, has body issues, toileting issues, overeats, has poor hygiene, takes no responsibility, argues, and makes veiled threats to those who try to help. When you first meet Lexi you see a thoughtful and engaging child. Over time the cracks become more apparent and at times it is difficult to establish what is real and what is part of some story she is involving herself in. But you never forget the first meeting or forget what is beyond the chaos that her life has become. She is so deserving of love, especially when you consider her journey to now.

Lexi was born to a substance-abusing father, Peter, and a mother, Sandra, who was not capable of showing her daughter the love she deserved. Sandra was plagued by mental health issues, poverty, occasional homelessness and an unreliable partner and it was not long before Lexi came to the attention of the social services. Indeed, Sandra has had three other children who have gone through the care system, two to adoption and one in a long-term foster placement.

Lexi was alone and all but abandoned in the early weeks of her life. Through the intervention of a social worker a foster placement was sourced, and Lexi moved when she was just a few months old. Thus began a series of moves from short-term emergency placements to more long-term ones. At one point Lexi returned to her parents' home from a foster placement where she was said to be thriving. Her parents had completed a parenting course and her father had been clean for some time. A little over a year later Lexi was on the move again. At the age of six Lexi had moved seven times. The next foster placement lasted four years and was to be catastrophic for Lexi.

When you consider the number of people working on Lexi's behalf it is quite daunting. Directly or indirectly, I can count 28 people who are working for or with Lexi. These include the staff team at the centre where Lexi lives, the social work team, support workers, doctors, therapists, teachers and her recently appointed guardian ad litem. It is important that we all have a good sense of what the others are doing, but more important is that we respect what it is we are all doing. From the social care worker who wakes Lexi up for school, gives her breakfast and sits with her as they discuss the day ahead – or anything, really – to the teachers, therapists, social workers and decision-makers, a level of understanding and respect for the roles they play, and for the tasks within these roles, for each other and, most important, for Lexi, is essential, not only for clear communication but for producing the best outcomes for her.

It is difficult to have a clear understanding of the term *respect* in a professional setting. Do you respect someone you don't like? Do you respect someone who can have a huge influence (positive or negative) over the life and welfare of a service user? Do we respect those who have unacceptable goals, such as lapsing addicts? Do you respect a colleague who appears to have a limited focus on events and appears to you and others to have formed an opinion of a service user and is then acting according to this view, to the neglect of others'? How do we address these dilemmas?

Definitions of respect include links with dignity, moral obligation, human rights, respect for cultural differences, reflection on professional relationships, ethics and the culture of respect (Hicks 2011; Beach *et al.* 2007; UN 1948; Gostin 1995; Hargraves & Page 2013; Paasche-Orlow 2004; James 2018). Dictionary definitions include: 'a feeling of deep admiration for someone or something elicited by their abilities, qualities, or achievements'; 'due regard for the feelings, wishes, or rights of others' (Oxford Dictionaries); and, 'Respect is a way of treating or thinking about something or someone … People respect others who are impressive for any reason, such as being in authority – like a teacher or cop – or being older – like a grandparent. You show respect by being polite and kind' (vocabulary.com). To my mind these definitions fail to recognise what respect is; neither do they note differences between people and ideas. Perhaps one of the better definitions might be: 'Respect means that you accept somebody for who they are, even when they're different from you or you don't agree with them. Respect in your relationships builds feelings of trust, safety, and wellbeing. Respect doesn't have to come naturally – it is something you learn' (Kids Helpline); this definition identifies difference and notes that respect is a learning event.

Beach *et al.* (2007) explore the concept of respect as having a twofold meaning; the exercise of 'personhood' and a moral obligation. They note the autonomy of service users but add that respect is independent of a person's characteristics, and therefore ought to be accorded equally to all. They argue that there is a cognitive aspect – respect acknowledges 'value' in others; and a behavioural one – which impels us to act in accordance with this belief. This moral duty is not to be reduced to politeness, honesty or deference to a service user's wishes. *Personhood*, meanwhile, is described as 'an essential characteristic of the human species' that 'gives to the human individual a universal worth and an exceptional standing' (White 2013). Warren (1973) listed six criteria for personhood: consciousness, reasoning, self-motivating activity, capacity to communicate, presence of self-concept and self-awareness.

The role of relationships with our professional colleagues could perhaps be a mirror of sorts of the relationships we have with our service users; our attention to detail, for example, or how we respond to situations. The value we hold for the service user or colleague might impact on how we respond, and we need to be mindful of this. In my professional practice I can see how sometimes judgement of others, if not checked in supervision or with ourselves, can impact on professional relationships. How we communicate is very important. While social care workers by nature can be very expressive, our greatest tool is our ability to listen and to identify important information. Within this listening space we can identify not only what needs to be done for the service user, but also something of the person delivering the information, and how much they are involved with the case. We may disagree with something, but healthy professional relationships are not mutual agreement committees, rather platforms where debate can happen and progress can be made. Respect is central to this. Acknowledging another's difference is another way to see their individuation, self-identity and personal identity. Mutual respect and trust are also nurtured through consistency of approach, by reliability and by how we are seen to behave towards others. The value we attach to others, and its reciprocation, creates a space where respect can be shared. Self-awareness allows us to respond in a timely and mannerly way. Self-awareness also allows room for difference, in personality, approach, work style and delivery. Constant reflection and learning will only increase our ability to acknowledge and show respect and to create spaces where our shared goals can be achieved, and for great work to be done.

Empathy

Case Study (continued)

When a neighbour raised her concerns regarding how the foster children were being cared for in the foster home it began a process that is still unravelling today. What started out as a complaint about Lexi being threatened with a hairbrush while on a family holiday became a full investigation into how she had been treated throughout the placement. Stories of emotional and physical abuse followed, and later allegations of sexual abuse came to light. It appeared that Lexi had become the scapegoat. She took the blame for others' misdemeanours within the home (she was one of two foster children, and the couple had three other children of their own), faced the wrath of an angry man, was neglected and has spoken of being left with strangers while her carers went partying. Lexi later moved to another foster placement, but sadly her new carers were not equipped with the skills to care for her increasingly erratic behaviours. Lexi moved again two years later, this time to a residential placement where she now lives.

Among the most important skills a social care worker can possess is the ability to communicate effectively, and it is important that healthcare professionals understand people's feelings, experiences and perspectives in order to assess and identify the needs of that person. 'Empathy among health care users and professionals significantly contributes to how both groups behave as well as to their therapy and overall well-being. The development of empathetic skills constitutes an important priority in the education of health and social care students' (Moudatsou *et al.* 2020: 6). Sympathy and empathy are both acts of feeling, but with sympathy you feel *for* the person; you are sorry for them or pity them, but you don't specifically understand what they're feeling. 'Empathy is understood as a more complex interpersonal construct that involves awareness and intuition' (Moudatsou *et al.* 2020: 2), and can best be described as feeling *with* the person.

In the day-to-day shared experience with service users the use of empathy can yield positive results, among them improved relationships, creativity, trust and more harmonious living and working experiences, as challenging behaviour is better understood and responded to. In addition, a consequence of empathy can be a greater willingness by the service user to take risks in education, the community or life in general, as well as a greater chance of making the necessary changes that might lead to recovery from past hurt. In my practice with Lexi I am informed not only by the person in front of me but by information garnered from all available sources. I cannot help but be moved by her plight and how through her behaviour she re-enacts old wounds. My understanding of her case, and also my understanding of my relationship with Lexi, is significant; but more important, it is my ability to empathise in those moments where Lexi takes risks and lets us see her pain, or her dreams for her future, that are the building blocks for future progression and development. To catch these moments, and to bring them to our colleagues and advocate for Lexi, is a kernel of our mission as social care workers.

There is much written about the professional-service user relationship and the use of empathy. However, the use of empathy among professionals in their relationships with each other is not written about so much. It seems that if empathy is a tool for understanding the perspective of the service users it is not one that we choose to recognise often enough when working with each other.

Within interdisciplinary teams I witness empathy between people and I see the types of skills people use with the service users in evidence between us professionals. People who understand the professional/personal situation someone might be in are less likely to judge but not afraid to engage around areas of care. These skills would include communication skills, but what is also notable is that one professional has a good knowledge of the other, as a person and as a professional.

The situation between social care workers and the multi-disciplinary teams is less empathetic. Social care workers can be mistrustful of social workers and other professionals who, as they see it, only see the service users a fraction of the time social care workers do, while apparently wielding far more power. As a result, social care workers can feel not listened to, while complaining that they are in the perfect position to effect change. Social care workers have also been criticised in studies: for their inability to deal with children's problems (Clough *et al.* 2006; Hayden 2003); for being more reactive than proactive (Colton 2002; Berridge & Brodie 1998); and for at times assigning too much blame to the system for their problems (Smith 2009, cited in Brown 2016: 65). Brown further notes that, given these criticisms, it is inevitable that residential workers experience a long-standing inferiority complex (Gharabaghi 2008) and lack of confidence in their work (Howard 2012, cited in Brown 2016: 65). Brown notes that 'the realignment of the role of residential social care workers and cognisant disciplines needs to be re-configured in a way that acknowledges the pivotal role of residential care workers in the child welfare system' (2016: 70).

Social workers meanwhile have increasing demands placed on them as caseloads become larger, more rules are implemented, and they face greater expectations around performance (Wacek 2017: 5). Studies also note the level of stress and burnout among social workers (Acker 1999; Egan 1993; Lloyd *et al.* 2002; Wacek 2017). Hohman (2012) notes that despite being noted as central to the role, social work practice was not characterised by empathy. Antonopoulou *et al.* (2017) ask, 'is the social worker vulnerability to and experience of high level of stress likely to act as an inhibitor to the cognitive and emotional processing of empathy in conversations?' (cited in Lynch *et al.* 2019). Perhaps more work needs to be done to address the different roles each professional is playing in service delivery. A better awareness could lead to a more empathic understanding of the perspective of each professional. This in turn could lead to more trust and better working relationships, and consequently better outcomes for our service users. To support this idea, joint think tanks could be created where open discussion could take place and differences and difficulties could be aired. More professionals' meetings and better explanations of decisions will bring about better understanding of each other's roles and how it is a combination of all our struggles that produce quality care and better outcomes. This is discussed in more detail later in the chapter.

Labour of Love

Case Study (continued)

Lexi has a social worker, Pauline. She is Lexi's fourth social worker in six years. Lexi has begun to have a good relationship with Pauline. In conversations Lexi seems unsure of her social worker's role and cannot remember all her previous social workers' names. Lexi struggles at school and has a support teacher, Una, who has a really good relationship with Lexi, who visits her office a few times a week for a chat and some tea and biscuits. Lexi did have a play therapist but is now doing work with a psychotherapist and is preparing the groundwork for further work in St Louise's Unit, where her sexual abuse will be investigated more closely, and where, it is hoped, the correct supports and actions will be identified. She has been very reluctant to talk about this to date.

At the residential care home Lexi has a key worker, Polly, with whom she is developing a good relationship. Lexi speaks highly of Polly and most of the staff at the unit. She has also identified two or three other staff at the unit as being significant others and says she likes being minded by them. In conversations with Pauline, Lexi says it is her favourite placement so far and she has no desire to go to another foster placement. Staff at the unit are experienced in dealing with young people who present as Lexi does and are mindful of the hurts she has endured and of the repercussions of these. However, there are problems in their day-to-day dealings with Lexi. Arguments about favouritism persist and Lexi gets into a lot of arguments and rows with the other young people at the unit. Lexi is prone to rages and while she does not lash out physically at staff she does quite often scream and threaten to make complaints; and she runs from room to room banging and clattering into people and furniture. Nervous, excited, out-of-control laughter often turns to tears and upset. It is said she craves one-to-one contact, and this is provided. Polly and others set aside time for regular sessions in the house and outside in the garden, where they play, talk or watch Lexi's favourite programmes on TV. Lexi particularly likes the garden and, weather permitting, plays outside quite a bit. She sits on the swing on her own from time to time, just gently moving on the swing and not looking anywhere in particular. Staff are mindful to leave her to her thoughts as this seems to be serving some purpose we have not yet figured out. However, she seems more collected after her time there.

Lexi attends her doctor for ongoing issues. She has some toileting difficulties and in addition to this has some small mobility issues that have been identified for occupational therapy. She attends her dentist every six months and has had some fillings and some other work to correct dental problems. She needs much encouragement to attend to body matters – hygiene is an ongoing issue. And Lexi loses everything! Clothes, shoes, schoolbooks, mementos, gifts … While schoolwork is problematic it is not the most pressing problem.

Lexi is fourteen.

Note: All names have been changed.

In her article 'Care Work, Capitalism and the Labour of Love', Erica Lagalisse argues that 'because "care" is implicitly presumed to be *not* work – but rather an act of love – […] one [needs to] put the word "work" after it to suggest its productive and strenuous aspect' (2019: 1). She further argues that that relative assumptions in society about what is productive, of economic value, and what are 'natural' socially enforced activities, has led some to see 'care' and 'work' as separate activities. 'In short, it is only because "care" is imagined as the natural activity of women that it is not automatically conceptualized as work … The woman who expects (better) financial pay for the activity of caring for others in hospitals, elderly care facilities and pre-schools is also suspect: She should be drawn to this form of employment out of her natural feelings of care for others – which do not therefore constitute a "skill". The man who expects (better) pay for the activity of caring for others in the commercial sector is also misguided – he is only doing (unskilled) "women's work" after all' (2019: 2).

Anecdotally, social care workers will tell you of being asked, 'Just what is it you do?' and of people having no real understanding of what social care work is actually about, other than 'caring'. 'Misconceptions abound, and in many cases practitioners are not afforded the recognition or status they deserve' (Lalor & Share 2009: 3). Byrne-Lancaster (2014) writes, 'Lack of recognition is perceived as one of the blocks to professional identity … and … this is particularly evident in Irish Social Care' (2014: 2). Lalor and Share note a 'dearth of authoritative written material or academic research related to the area. Social care syllabi have tended to draw on elements of knowledge from social work, sociology, social policy, psychology and a broad range of other disciplines' (2009: 5). This situation is slowly changing as the last few years have seen several books and articles devoted to the practice of social care with much of the material written by practitioners themselves.

Byrne-Lancaster writes of a lack of recognition among health and other professionals: 'One of the major barriers to Social Care recognition by other professionals lies not so much in Social Care's diverse areas of employment, but in lack of clarity associated with Social Care's "outcome": what is the outcome of a Social Care Worker being involved in a service user's life' (2014: 2). She notes that CORU's definition of social care – 'a profession where people work in partnership with those who experience marginalisation or disadvantage or who have special needs' (2012) – suggests a social justice element and a political dimension. To this she adds her own definition of social care. which recognises both the day-to-day shared experience with 'more productive coping mechanisms and prosocial behaviours and a political element being introduced to the Social Care Worker role' (p. 7). She writes: 'Social care is a profession with the purpose of supporting the holistic growth, societal and political engagement of vulnerable people which is underpinned by partnership, advocacy and professional accountability' (p. 7).

Byrne writes of love in the context of practice and notes that in 'Irish "professional" social care, to feel love for a client is considered inappropriate. It is a blurring of the professional boundary' (2016: 155). 'The bizarre irony is that as Fr. Mc Verry explained, if you want to get a job in Irish social care, the one thing that you have to show is a sense of compassion for vulnerable people. The question then is; what is the difference between love and compassion?' (2016: 155). Byrne notes passion and compassion as being 'essential qualities for a social care worker' (2016, p155) and reminds readers that one of our tasks as social care workers is to provide love and security to troubled people, within a safe 'professional' relationship.

The fact is that social care work is a very skilled job. It involves complete commitment and skills many do not have; patience, communication skills, research skills, the ability to interpret and reflect on large amounts of often conflicting information, to set boundaries, to challenge, to write, to attend meetings, to advocate, to make dinner and help with rooms, to sit and hold broken people and to tell them that you will not ignore them. It involves a mixture of domestic, sensory, practical and creative skills, and yes, it's very hard to describe. I sometimes wonder if our fellow professionals have a clear understanding of what it is that we do. It is not 'women's work'; it is not unskilled labour; and no, not everybody can do it; and yes, we bring a lot of ourselves to the role, which is why most of us can say we love the people we work with. In our work with Lexi we seek at all times to hear and interpret the child's voice. We talk with Lexi about her care plan and placement plan, careful to put this into language she can understand. We discuss the environment she lives in and changes she may want; from the decor in her room to where she wants to go on holidays, the clothes she wants to wear, to what clubs are available to her within her community, to education and access arrangements, and we discuss the reasons why we might make decisions she may not like. We also encourage Lexi to talk of what is hurting her at any given moment and try to help her make sense of some of the wrongs associated with her life up to now. We do not seek to fix everything, but we do seek to give Lexi opportunities she has not had in the past.

We are acutely aware of the impact on Lexi of marginalisation and disadvantage, and we address this through advocacy and representation at meetings with our fellow professionals. We also acknowledge the political dimension noted by Byrne-Lancaster (2014) and indeed in the *National Standards for Children's Residential Centres* (HIQA 2018), which state: 'Each child experiences care and support which respects their diversity and protects their rights in line with the United Nations (UN) Convention on the Rights of the Child' (Theme 1, Standard 1:1). I am hopeful that over time and through statutory registration, increased accountability and improved educational opportunities social care will have a much clearer professional identity, and that our role in relationships with our professional colleagues will be better understood. Improved understanding and respect for the roles each of us play in the life of our service users can only be of benefit to all.

Discussion

In this chapter I am using the Lexi case study to discuss our understanding of the role of relationships between professionals. My work with Lexi is very varied. I play chasing and football and go for cycles with her. I also watch a lot of children's TV and discuss the merits of various rap and pop music she listens to. I help her clean her room sometimes, but she prefers the 'girls' to help her with this. I cook with her and I also sing stupid songs that make her laugh out loud. I sometimes tell her off for some misdemeanour and she sometimes tells me to 'fuck off' because she doesn't like what I said.

I also write daily reports of her life at the centre. I write weekly reports to her therapist (at the therapist's request), regular keywork reports and fill in all the logs associated with her care. I monitor and maintain the care plan and the placement plan in conjunction with the social worker, the staff team and the management. I also have regular phone calls with all the professionals in Lexi's case and attend weekly staff meetings where I report and advocate for Lexi. In addition, I attend regular supervision where I reflect, gain support and garner ideas that will further support the work we, Lexi and I, are doing; and indeed, all the work I am doing with the other young people at the unit. In addition to this I also attend two group consultations per month, facilitated by the centre and involving the staff team, where the work we do with all the young people and the impact on us as people and professionals is discussed. I do maintain and enjoy good relationships with the other three young people at the unit and spend time and do activities with them as well.

I came into work one day and Lexi was running around the centre screaming and crying. The only sensible thing I got out of her was that she didn't know why this was happening. I took her in my arms and held her for some time. This was not a restraint. This was a hug. She cried and held on for a while. When she was a little calmer, I suggested she have a bath, lots of bubbles, and relax for a while. I asked that a female colleague of mine sit outside the bathroom and not move for the duration of the bath Lexi was going to have, and she did this. I also told Lexi what I was going to do so there were going to be no surprises. Lexi sat in the bath and talked non-stop for about forty-five minutes. Most of the talk was about nothing at all, certainly not about the reasons why she had got so upset and frightened earlier. After her bath, Lexi spent time in her room with my colleague talking and listening to music. She never told me why she got so upset that day.

The role I have with Lexi is hard to describe, especially to someone who does not work where I work. It must be difficult for other professionals to understand this too. I also do not fully understand what the social worker does, or the therapist, or any of the other professionals in Lexi's case. However, I trust they are good at their jobs and I have good relationships with them overall.

One of the things that bonds us as a 'workforce' and strengthens professional relationships is the nature of the work we do and the adversity we sometimes encounter. We social care workers need to get support from our colleagues so that we may in turn have the fortitude to give this support back to our service users. The building of relationships within the group we work with, the expressions of support, love and empathy, have helped create a very resilient team; and one where trust and respect are very evident throughout our practice. Many of us come to social care from very different places. Some of us have natural people skills but lack the academic skills this industry is asking of us. It is important that opportunities are provided for social care workers to increase their knowledge base in a way that does not overload them. Brown writes, 'Development of training on therapeutic models in the United Kingdom has proven to significantly improve residential care practice' (2016: 46). Access to supervision, outside supports and continued access to academic resources will also support our ability to practise at the highest level.

With the imminent statutory registration of our profession and its emphasis on mandatory continuous professional development (something most of us do anyway through reading, attending training, supervision and reflecting on practice), audits of practice and a professional code of practice and

conduct I would hope our profession will be seen in the same light as others whose professions are regulated (such as nurses, midwives, medical doctors and pharmacists) and that the sceptics will have a better understanding of social care work.

There is a need for all those involved in social care practice to understand the roles of the multidisciplinary teams better. One idea to support this increased understanding is for the establishment of groups, or 'think tanks', set up to study social care. Think tanks are invariably not-for-profit organisations and engage in research and advocacy in a range of areas such as social policy, politics, economics, security, the environment, science and technology, "Think tanks share a common vision to improve their respective spectrums, as well as being sources of new ideas and research" (University of Oxford 2021). There are already good frameworks available through colleges, Social Care Ireland and some social media groups dedicated to social care. Perhaps more harnessing of common ideas throughout these would be a great way to start.

The use of study and focus groups could further help support our understanding of the many relationships and working practices that exist throughout social care. Regular analysis of changes in attitudes, thinking and practice would be easier to notice and respond to where necessary.

Additionally, more sharing of reports and increased use of professionals' meetings will give each member of the multi-disciplinary team the opportunity to discuss their role with each service user. They could also be forums for understanding different perspectives involved in the decision-making process, of the risks involved, and, for the questioning some of these decisions.

Training events can be seen as opportunities for formal and informal contact with our colleagues. Perhaps more sharing of training events and within these more sharing of viewpoints would contribute to more trust and mutual respect among professionals. This happens already in many areas such as Children First training, challenging behaviour and more recently understanding trauma training days. Furthermore, the invitation of professionals from one discipline to address another team directly would greatly support better understanding of their work with our service users. At the centre I work in we have invited therapists and others to address the team and discuss the nature of their work. This type of training and shared experience has greatly helped our understanding of their role and consequently increased our respect for what it is they are doing and, indeed, has guided us as to how we can approach different situations in a new way.

Conclusion

This chapter discusses how each of the professional relationships contributes to Lexi's overall care plan. It lists the number of professionals in her case. The importance of respect and empathy and how understanding others' perspectives is key to better outcomes for Lexi is also discussed. The chapter also maintains that the kind of relationship I have with Lexi, where respect, the ability to listen and communicate appropriately, attention to detail and effort can be a mirror to the type of relationships I need to have with my fellow professionals. This chapter also looks at the different ideas and misconceptions people have about social care work. The elements of social justice and political dimensions that are now becoming more significant are also discussed. The concept of love in the context of practice is also discussed and I have noted the irony that some people feel it is inappropriate to show love to a service user and yet the job spec asks us to be passionate about the task and compassionate about the service user.

In an effort to further understand relationships within the multidisciplinary team, I outline suggestions for how they could be improved or nurtured in the Tips for Practice Educators section. These include strengthening of relationships using think tanks, focus groups and training days; the use of professionals' meetings and the invitation of different professionals to address the staff team and discuss their work with young people. And we would be happy to do the same if we were invited.

This week was interesting for Lexi. She saw her father at a bus stop. This was the first time in six years that she had seen him. He 'didn't look too good' was what she said. I will inform the social worker and anyone else who needs to know. We will mind Lexi and encourage her to talk – she might, or she might not – about how she feels about it all. When she is ready, she will.

Tips for Practice Educators

There is a need for all those involved in social care practice to understand the roles of the multidisciplinary teams better. Ideas to support this increased understanding include:

- The establishment of think tanks to discuss each other's roles with a view to increasing our understanding.
- Study groups and increased use of focus groups to further support this understanding.
- More use of professionals' meetings will increase the standing of each member of the multi-disciplinary teams as they are afforded the opportunity to speak of their actual role with the service user in a clearer manner.
- Regular reports shared between us professionals will enhance the understanding of how and why decisions are made, and recognise the various risks attached to these decisions.
- Attendance at different training events and the provision of formal and informal access to communication will increase the overall relationship base between professionals. Social care workers' attendance at training aimed at social workers, and vice versa, would also contribute to increased trust and mutual respect among professionals.
- Another idea could be that professionals, social workers and others could address social care staff teams directly and discuss their roles and their thought processes.

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Chapter 39 – Marian Connell

Domain 2 Standard of Proficiency 16

Understand the principles and dynamics of group work in a range of settings and be aware of the role of different facilitation techniques to improve outcomes and enhance the participation of service users in care.

KEY TERMS

Group work in social care practice

Key principles and dynamics

Facilitatation

Co-facilatation

Social care is … about being in relationships with another, compassionately understanding their narrative to help and support them to flourish in all aspects of their lives.

Social care work is about being mindfully present in relationships with the service users who we are striving to help, empower and support. Professionalism is at the core of social care work, ensuring that we are deeply connected to our service users. The core principles of social care work include respect, dignity, compassion, being congruent while advocating for and holding the person in high regard, and doing your best for your service user at all times, while looking through a social justice lens.

Working in groups has become an integral part of social care work in a variety of settings and helping students to understand the nuances of this while also providing them with an opportunity to develop facilitation skills is a fundamental part of the students' social care training.

CORU (2020) defines social care work as 'a relationship-based approach to the purposeful planning and provision of care, protection, psychological support and advocacy in partnership with vulnerable individuals and groups who experience marginalisation, disadvantage or special needs. Principles of social justice and human rights are central to the practice of social care workers.' Lalor and Share (2013) also allude in their definition of social care to working in groups in a wide variety of settings.

This chapter will define group work and explore the principles of working with groups, based on my own experiences in social care practice and education. The principles of group work include understanding group dynamics and how enhancing your facilitation skills can increase service user participation and improve outcomes.

What is Group Work?

McGovern (2016: 65) states that 'Groupwork is meaningful face to face contact by those who come together in a common space for singular or multiple sessions. It is a relational, purposeful, informed and collective activity which is designed to be helpful and responsive. Groupwork looks to the needs of the individual or group with regards to change or improvement in conditions or behaviours and in some cases for task accomplishment.' Lindsay and Orton (2014) explore this further offering a working definition of social group work as engaging in meaningful group experiences to help participants to meet group wants and desires to inspire personal growth, and group development to bring about positive change. Doel and Kelly (2014:97) define a group as 'three or more people who are connected and interdependent, usually to accomplish a shared purpose'.

Relational work is at the core of social care practice. Looking at the needs of the individual combined with the needs of the group can bring its own challenges for a social care worker. Mac Giolla Ri states that 'Social care workers are well placed to identify creative interests, plan, organise, facilitate, support and provide safe creative activities …' while being cognisant of limits of their practice. Getting the balance of meeting both the individual's goals and the group's goals can take a lot of expertise and skill on the part of the social care worker. Group work training is recognised as an integral part of social care undergraduate training. In our university, we have a module called Creative Group Work and Facilitation Skills, which is designed to explore the complexities of group work in social care settings. We also ensure that students have exposure to group work activities throughout their four years in their undergraduate training, ensuring that they achieve this proficiency.

Social care workers may engage in group work in a variety of social care settings, for example: an advocacy group in a day centre or residential centre for disability service; reminiscent groups for older people; a children's social skills group in the community; residents in a hostel/residential home having a house meeting; a domestic violence group; a parenting group in a family centre; or a group of young offenders attending day service. When we consider group work we generally have the idea that people are willing participants in these groups. From my experience of social care practice, I know that some group participants do not want to be present and have a lot of resistance to being there. Examples could be a parent who is court-directed to attend a parenting course to prove their capacity to parent, or a young person who is involved in crime mandated to attend a youth diversion programme. Indeed, this is often reflected in the classroom setting. Some students struggle with group work, can present with resistance and are often unwilling participants. Providing learning opportunities for students to process these issues within a safe learning environment is crucially important.

As a lecturer I begin our module by delivering creative sessions in our weekly tutorials, drawing on my postgraduate training in creative arts integrating mindfulness, creative arts, drama and Lego. Students have the opportunity to participate and to experience creative arts in different formats. Creative arts can be a fast track to the unconscious (Case & Dalley 1992; Jung 1953; Vasarhelyi 1990). Students get to experience this for themselves in a safe and contained holding environment (Bion 1962, Lyons 2010, Fawcett 2014). Students are afforded the opportunity to reflect on the creative process and their own personal response to it. If students have a traumatic response, student supports services are offered, as well as providing a space to discuss issues arising, if appropriate, for the group setting. These issues are expanded upon by McGovern (2016): 'for the lecturer or group leader teaching groupwork can be a creative and cognitive challenge. Being available to each class member and the class group, while checking one's own practice skills and knowledge, requires a delicate work balance. Groupwork teachers therefore need to self-check their capacities regularly thus avoiding burn-out or lacklustre practice.' As a lecturer, it is important to ensure that self-care skills and techniques are modelled at all times in order for the student to learn from practice. Johnson, & Long (2020) also allude to the importance of social care educators having to ensure that their students meet the standards of proficiency on self-care and professional development. Time management, boundaries and turn-taking are also adhered to during these opening facilitation sessions. I would also select creative interventions where the room is set up in different styles so the students can experience seeing the room set up to match the creative intervention and meet the needs of the service user.

TASK 1

What self-care skills have you developed as a social care student?

How do you incorporate them into your daily life?

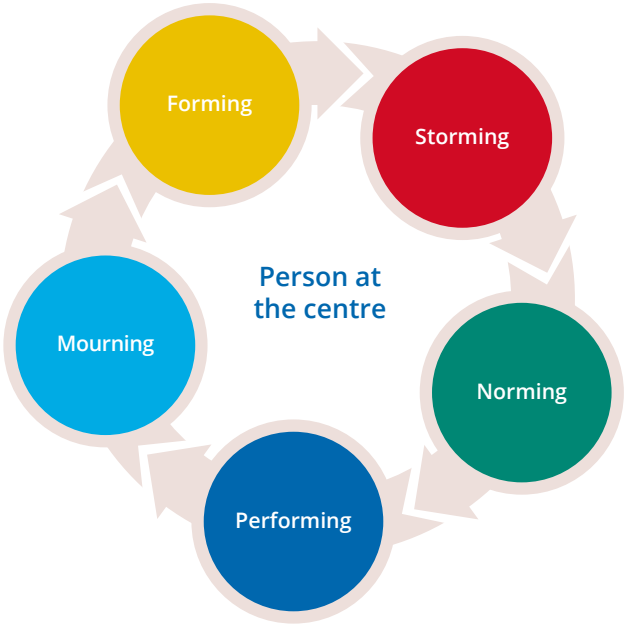
Key Principles and Dynamics in Group Work

Group Dynamics

In exploring theories of group work, Tuckman's (1965) linear model can be examined:

It has five distinct stages:

1. Forming
2. Storming
3. Norming
4. Performing
5. Mourning



(Lindsay & Orton 2014)

Conflict often occurs in groups at the storming stage. Benson (2019: 80) posits, 'The group worker who accepts that conflict is a central feature to group life and is attuned to aggressive and destructive forces is much more likely to be able to manage and channel these processes than a worker who is frightened by conflict and seeks to avoid or deny their presence.'

Principles underpinning group work

Douglas (1976), Friedlander (1958) and Konopa (1963) identify the following key principles of social group work:

- Genuine acceptance and recognition of individual strengths and weaknesses through the conscious use of self-reflection and critical reflection.
- Building purposeful relationships between the social care worker and group members.

Verma (2010) lists twenty-three key principles of group work, including all of the above, and notes the importance of incorporating key principles of equality and understanding, and of utilising relationship as a key tool for problem-solving and promoting self-development. Understanding group process, conflict, the importance of values and new opportunities are also cited as key principles to consider when forming groups.

It is very important to be cognisant of this when teaching social care workers the importance of group dynamics and exploring the advantages of group work.

Trevithick (2005) cites the importance of having a sound knowledge base of group work that draws on:

- theoretical knowledge
- factual knowledge
- practice knowledge.

Geldard and Geldard (2001: 4) outline five advantages of group work.

Five Advantages of Group Work
1. Groups can promote change: For example, through the power of the group the service user may be challenged to achieve their needs.
2. A group can parallel the wider social environment: In a group setting a member may learn to turn-take, to listen and build sustainable friendships.
3. A group provides a sense of belonging: As a group participant the service user may build their social support circle.
4. Common needs can be addressed in a group: Groups are often designed to meet common goals and help service users meet people who are in similar situations to them
5. Groups are cost effective: For example, eight service users may be seen by two facilitators in a two-hour slot, making the group cost-effective for the organisation.

Facilitation and Co-facilitation

Fundamental Principles in Teaching Group Work and Facilitation in Social Care Practice

According to Schwarz (2017: 14), a group facilitator is a person who:

1. Is not a member of the group
2. Is content neutral
3. Has no content decision-making authority or input
4. Is acceptable to all members
5. Diagnoses and intervenes in a group
6. Helps to improve the process by which the group identifies and solves problems and makes decisions in order to increase the group's effectiveness.

Benson (2019) cites Lieberman *et al.* (1973) and Coyne and Diederich (2013): 'four basic functions of a group facilitator [are] caring, affection, acceptance and support', drawing on Rogerian (1957) core principles which have been integrated into social care practice.

McGovern (2016) postulates that teaching group work at a university level must expose students to key principles, theoretical frameworks and models, roles and skills. She highlights the importance of exposing students to critical reflection, leadership and co-facilitation through participation and experiential learning, while also teaching the skills to manage and deal with conflict. Trevithick (2005) cites the importance of including theoretical and practice themes when teaching group work:

- Knowledge base group work
- Advantages and limitations of group work
- Leadership styles and approaches
- Group roles and the importance of being aware of defences
- Understanding family/team as a group
- Developing a toolbox of ice-breakers, creative group games and activities.

The importance of a social care worker developing specific skills such as empathy, communication, active listening, exploring silence and being able to clearly explain the purpose and benefits of the group participation are cited by Verma (2010).

In our Creative Group Work and Facilitation module, we provide opportunities for students to be exposed to different theoretical frameworks and models and to become aware of skills that they may need. Students will have the opportunity to engage in personal reflection in a group setting, to co-facilitate a group work session, and to be able to recognise group dynamics and develop strategies to deal with conflict as it arises in their experiential learning classes. Each student gets the opportunity to participate in classroom learning through experiencing their lecturer facilitate creative classes. They also have the opportunity of witnessing their peers co-facilitating a variety of creative interventions, in which they can participate and gain worthwhile experience while also having the opportunity to peer review their peer's facilitation skills.

Some of the following issues may be important to consider when students are planning their group.

Group Contract

It may be worth considering having a group contract, which might include:

- Aims and objectives of the group – must be clear
- Group profile – matching your group takes considerable thought.
- Group rules need to be established with the group members
- Exploration of the limits of confidentiality
- Structure of the group – times, dates
- Expectations around participation and attendance
- Taking responsibility for self within the group – self-disclosure.

Establishing Clear Ground Rules and Building Relationships

Clear ground rules need to be established in the first session. Take the example of a parent being mandated to attend a parenting programme to assess their capacity to parent. Very clear limits of confidentiality need to be established from the opening session to ensure that group members are very clear what needs to be shared with external agencies. It is worthwhile considering what is expected regarding attendance: are group members expected to attend all sessions? If there is poor attendance, how will this affect the group dynamics?

Starting times and finishing times must also be considered. Clear boundaries need to be held by the facilitators to ensure good practice. Facilitators must arrive early to set up the room, be present to welcome group participants and ensure (if appropriate) that refreshments are available for the group. It is not advisable for groups to start late and extend the time boundary at the end. Boundaries help group participants to feel safe and secure, and extending time boundaries will not help with this.

Room Space and Safety

Think about the room space that you use and give due consideration to risk assessment. It is crucially important that you use the same room each week with the room laid out in the same way. This adds to the group participants' sense of security.

TASK 2

Take a few moments to reflect on where you sit. Do you have everyone sitting in a circle? Are you standing up when everyone else is sitting?

How might this be perceived by the group?

What considerations have you given to the layout of the room?

Challenges and Limitations

It is also important that you consider how you allocate time to each group member. From my experience of facilitating groups it can sometimes be a challenge for a group member to find their voice and you may need to reflect on how each member's voice can be heard. Having a 'round' at the beginning and end may assist with this as each group member can then have the opportunity to say what they wish. Having the right to pass without saying anything may also be worth considering. Group work can be very emotional at times and group members may be triggered by the subject matter and may not feel able to speak openly. Having what I call a 'loose neck' is really important; in other words, as a facilitator you must be able to see what is going on with the group members at all times. Be attuned to their changing facial expressions and body language. If you think a group member has been triggered emotionally it is important to leave space and time to explore this. Perhaps it may be appropriate to reflect on this in the group session or afterwards on a one-to-one basis.

Another challenge I have experienced is a member who over-talks or over-shares in the session. Setting clear group rules in the opening session may help with this. However, it is sometimes important to know when to shut a conversation down. Perhaps it may be necessary to say 'Can we hear from someone else in the group who we have not heard from already this morning?' or 'I wonder what other group members' views are on this.'

It is important to plan group activities well and ensure that you can draw on your creative toolkit. Occasionally a facilitator may need to change the group's direction if it is not facilitating the expression of feelings and emotions. It is important when devising a creative group that you have a back-up plan in place that you can draw on as required. However, some group programmes have set weekly sessions, for example the Incredible Years programme, Cooperative Parenting and Parents Plus. A challenge in this situation is to ensure that you know your material extremely well and that your and your co-facilitator's roles are clearly identified. Endings must also be considered. Many service users may have experienced traumatic endings in the past and this is an opportunity for facilitators to allow the participants to have a positive ending with a planned ritual attached.

TASK 3

Reflect on your own experience of facilitating a group work session or participating in a group.

How do you manage conflict?

What challenges you in relation to co-facilitating with your fellow students?

What style of facilitation would you like to adapt?

What do you hope to learn about facilitating/co-facilitating a group?

Planning, observation and evaluation are key components in group work. (Timoney 2010; MacGiollari, Doel & Kelly 2014). Time needs to be allocated to this process with your co-facilitator. Social care workers must be open to critical reflection in group facilitation. O' Brien (2020:12) cites WHO (2018) which states 'Critical reflection is a core component of many evidence-based norms interventions. It is a facilitated process that encourages people to think about their ideas or assumptions, influence their actions, and explores and challenges that dynamic through probing questions'. Key reflections can include: what worked well in the group; what needs to be improved on; was every participant's voice heard?

To conclude, proficiency SoP 2.16, as outlined by CORU (SCWRB 2017) is crucially important for students to understand and experience. However, learning how to facilitate or co-facilitate and understanding the nuances involved in the delivery of group work is a challenge. This process of learning can commence in the lecture room, but it is one that is continuously developed as you grow and develop as a social care worker in practice and work as part of a multi-disciplinary team.

Tips for Practice Educators

Creative Art Exercise for Educators to Explore Boundaries

Requirements: A large sheet of paper approx., 3.5 metres by 1.5 metres, paint brushes, paints, paper plates.

The room is set up with a large sheet of paper on tables with room for students to move comfortably around. Paints, brushes, and paper plates are laid out in a separate table.

Aim: To explore boundaries through creative arts.

Participants: Max. 10

Ask the students to choose two paint colours, put them on a paper plate and take a space at the table. Ask them to close their eyes (if they feel comfortable to do so) and, in silence, mark out their boundary on the paper with the colours that they have chosen. Encourage them to paint and after five minutes ask them to move two places to the right.

After five minutes, ask them to move two spaces to the right again and continue to paint in silence. Then ask them to stop painting and comment in a round what the experience was like for them.

Issues around boundaries are discussed and what it is like to enter uninvited to someone else's space. When everyone has had the opportunity to share what this experience was like for them, they are invited to work together to finish off their creative image.

As a facilitator, notice how the mood of the group changes as the group works together to create their group image.

Having had previous experience in group work activities some students may hold on to negative experiences and avoid conflict. Through our experiential group work activities, our creative art exercise on boundaries facilitates the students to explore issues around boundaries.

Issues that have arisen in conducting this exercise include the fear of invading others' space and how to manage the conflict that may arise. Open discussion in the creative space can explore this.

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Chapter 40 – Tanya Turley and Diane Devine

Domain 2 Standard of Proficiency 17

Be able to recognise all behaviour, including challenging behaviour, as a form of communication and demonstrate an understanding of the underlying causes in order to apply appropriate strategies.

KEY TERMS

- Behaviour as communication
- Challenging behaviour
- Underlying causes of challenging behaviour
- Behavioural management planning
- Behaviour management
- Strategies for everyday activities

Social Care is … a human centred sector. Social Care is the recognition of the inherent value of human beings and the strength of the human spirit. It is working with and advocating for the most vulnerable in our society – with children, with adults, families, and communities. Social care is journeying on the life path of those who have entrusted us to listen to their stories. It is offering a holding environment when they are at their most exposed, helpless, defenceless and at risk.

Social Care is also a place where we advocate and give a voice to the voiceless, it is a place where we encourage a sense of belonging, of non-judgement and of acceptance of the individual. It is a place where respect is integrated into everyday life and relationships are cherished. Social Care is the place where personal, life skills and inclusion are promoted – it is the place where personal growth happens. It is a place where compassion and empathy are integral for all to be reassured, they are of value, their lives have purpose and have and give meaning on a personal level and equally to their family and community. Social Care is a privileged position where we recognise vulnerability as central to our everyday work and are faced with the complexity of human life – it is the place on a moment-by-moment basis where we are cognizant, connected, genuine in our understanding that each vulnerable person's life is important and matters.

TASK 1

Describe a recent experience where you felt you were not being heard or could not communicate your point. How did it make you feel and how did you react to or internalise this experience?

Behaviour as Communication

Everybody communicates through behaviour. Communication allows us to express our emotions and it empowers us to interact with each other. We are communicating something through our behaviour during every moment in every day, even if we are not aware of it. Behaviour is shaped by social norms and cultural expectations that are passed from person to person in our daily encounters as members of a family, a community and society (Eysenck 2002). Behaviour is our fundamental method of making

our voices heard as human beings, through our verbal and non-verbal communication. Understanding how our service user may communicate emotions, thoughts or feelings, either verbally or non-verbally, through sounds and gestures, is central to our role as social care workers.

TASK 2

Essential Reading

Before you begin, please read the following:

1. Eleanor Fitzmaurice, 'Managing Challenging Behaviour' (Chapter 13) in K. Lalor and P. Share (eds) (2013) *Applied Social Care: An Introduction for Students in Ireland*, Dublin: Gill Education.
2. P. Keogh and C. Byrne (2016) *Crisis, Concern and Complacency: A Study of the Extent, Impact and Management of Workplace Violence Experienced by Social Care Workers*. Dublin: Social Care Ireland.

What is Challenging Behaviour in Social Care?

All behaviour is communication, and behaviour that was viewed as an act of disobedience or non-compliance with formal authority was described as 'challenging behaviour' (Fitzmaurice 2013). The '*challenge*' was for the service to overcome in order to appropriately respond to the person's complex needs. However, the term '*challenge*' was interpreted as 'problem behaviour', a disruption, a form of hostility and potential violence (Fitzmaurice 2013). More and more professional groups are adopting alternative terms to describe challenging behaviour, such as 'behaviour that challenges' and 'behaviour of concern' (Chan *et al.* 2012). This in itself is constructive and its causes as it removes the negative and sometimes harmful label from the individual and places it on the behaviour. This can be very helpful as it supports professionals, family, peers and community in the person's life to understand and appreciate the whole person and objectively work with them in using tools and strategies to manage and regulate the behaviour, thus recognising that the behaviour doesn't define them as a person.

The main forms of challenging behaviour have been identified as aggressive behaviour, destructive behaviour, self injurious behaviour, destructiveness, hyperactivity and socially unacceptable behaviours (Emerson and Einfeld 2011: 6). The ways in which these behaviours are generally communicated are through conduct and actions that can be aggressive, assertive, passive and/or passive aggressive.

Kissane and Guerin (2010) describe the complexities of 'challenging behaviour' and how the person can present with behaviours that can meet with one or more of the following criteria:

- The behaviour causes repeated injury (e.g. bruising, bleeding, tissue damage), or repeated risk of injury, to self or others (e.g. hitting, head butting, biting, scratching others, spitting, biting, punching, hair pulling, kicking) and/or causes damage to property (e.g. throwing objects and stealing) or is stereotyped behaviour (e.g. repetitive rocking or echolalia).
- The behaviour seriously limits the use of, or results in the person being denied access to, ordinary community facilities (e.g. inappropriate sexualised behaviour – public masturbation or groping).
- The behaviour causes significant management problems (intervention requires more than one member of staff for control and/or the behaviour causes daily disruption for the duration of at least one hour (Fitzmaurice 2013: 182).

While the above highlights behaviour that may be viewed within certain social care settings it is important to note that challenging behaviour is often not as pronounced as this. Indeed, it can be obvious or antagonistic behaviours (see Mark and Jess in the Case Study below) or more negative actions that are indirect and undermine the relationship (see Kelly's Case Study – passive aggressive). Community Mental Health for Central Michigan (CMHCM 2012), in its training programme for managing crisis behaviours and de-escalation, describes challenging behaviour as conduct that can be considered under the following categories.

- Behaviour can be considered challenging when it affects an individual's life in a negative way, or the behaviour has a vast bearing on how others relate to them. For example, if the person is 'labelled' as having a behavioural problem or being 'difficult/challenging'.
- Behaviour can be considered challenging if:
  - It causes actual harm – physical, psychological or emotional – to the individual or to others.
  - It causes damage to property or belongings of self or others.
  - It prevents the person from learning new skills, forming or maintaining relationships.
  - It prevents the person from participating in social and recreational activities or if carrying out regular typical activities such as sports, drama, music, social groups necessitates risk management or a high degree of forward planning to carry out the activity (CMHCM 2012).

TASK 3

Read the four case studies and answer the following questions: what do you Think is happening, how do you Feel about the event, what Behaviour is being expressed, and what Action will you take?

- **Mark*** (9 years old) returns from school, asks 'Where are my headphones, you moved them, you took them, you bitch you robbed them, I'll burn the place down, I'll wreck it.' He begins to shout and kick, and punches the door beside where you are sitting.
- **Dean*** (16 years), a young man who presents as sullen and often on edge, comes into the club. It's his birthday and no one in his life has mentioned it. You start to sing (badly) 'Happy Birthday' and dance around with a chocolate muffin and candle while he responds, 'Shut up, you're thick and you can't sing.' One of the other lads starts to make negative comments about him – 'He's built like he's six, not sixteen' and Dean begins to get agitated and walks over to the young person who made the comment with fists clenched.
- **Kelly*** (38 years) refuses to answer your question about dinner, turns her back on you, stares at her phone, will not make eye contact, rocks back and forth while uttering something that you cannot hear. This is the third time this week this has happened when you speak with her. Then she makes a comment to another day service user who is nearby.
- **Jess*** (14 years) on late return to the house (emergency accommodation) from missing in care turns the radio on loudly in the kitchen, slams cupboard doors, opens and shuts presses, hums when you try to speak with her and begins constantly tapping the butter knife she removed from the drawer on the sideboard, 'This would cut, you know, it would hurt.'

* Names and Details have been changed.

Underlying Causes of Challenging Behaviour

As social care workers, the very 'challenge' in challenging behaviour may be to remember that the person's behaviour is a form of communication and at that moment they are trying to communicate something to us. According to Fitzmaurice (2013: 182) there are five elements to consider when developing a support plan for behaviours that challenge, which may help us as workers to understand what the person is communicating through the behaviour. These are biological, social, environmental, psychological and organisational.

Biological

This is behaviour as communication of pain or feelings of distress, anxiety, depression, neglect or frustration (Fitzmaurice 2013). From birth, infants are completely dependent on another person for their survival. Babies are born with three basic survival strategies – fight, flight, freeze responses – supported by the limbic system in the brain, which is triggered in reaction to different situations (Carter 1998). Through socialisation, upbringing and life experiences, people learn how to read situations, respond to people and control emotions and actions when in difficult situations or facing what may be perceived as confrontation. As adults, we keep the limbic system under control by rationalising and making judgements on the best outcome based on previous experiences. If an adult or child has experienced trauma, poor attachment or any experience that may have caused developmental delays, any new event that is perceived as stressful or challenging may cause the limbic system to become overwhelmed (Cairns 2002). In this case, the person or child begins to react without engaging the thinking part of the brain and responds with a fight, flight or freeze response (Carter 1998). Consider the Mark case study: What happened that day for Mark? Was there an incident at school? Is he tired or upset by something? At nine years old, is his biological system developed enough to manage profound emotion?

Social

This relates to adverse family situations, communication difficulties, boredom, maltreatment, seeking social interactions, the need for an element of control or independence, lack of advocacy, anxiety caused by lack of understanding in relation to community rules and appropriate behaviours, insensitivity of staff and services to the person's wishes and needs. These can all impact on behaviour (Fitzmaurice 2013).

As human beings we have an innate need for relationship, a sense of belonging to, attachment with, a 'container' to hold our thoughts, feelings and emotions (Bion 1962). For service users, or people who are acting out in a challenging manner, developing new relationships is a difficult process. By forming relationships with social care workers, and other professionals, they risk opening themselves up to the potential of caring and being cared for and the possibility of being hurt. Closeness or proximity to other people can cause a sense of uncertainty, raise emotions and trigger a sense of danger. It is often easier to be defensive, to lash out, to attack than to admit or be able to consider why they feel this way. Paradoxically, the human connection or closeness that can aid our healing, support us in times of crisis or keep us safe from harm, can be the trigger for the challenging behaviour. Think of Jess (who has returned home). You welcome her back, say, 'I am so relieved you're safe. Are you okay? Let me make you something to eat – what can I get you?' As a social care worker you want to 'care' – what happens when you try to display this care to Jess, if her previous experiences of relationships has been neglect, lack of care or inconsistent trust? How does she respond to you in this social situation and why?

Environmental

This relates to external stimuli, such as noise, lighting or change in routine, limits imposed by a structured setting, or an unsuitable physical environment. Winnicott (1965) highlighted the significance of a 'facilitating environment' in order to provide a safe space for children and young people to heal. Lack of a facilitating environment means the real work of healing, processing and building a relationship to soothe hurts cannot happen or becomes stuck. This does not necessarily mean that the environment must be physically perfect, but that at its core it has warmth, openness, a flexible structure ready to adapt to the needs to the persons accessing it or living within it (Ward & McMahon 1998). Things such as a favourite food on the shopping list or in the fridge, being able to incorporate people's favourite colours in a bedroom or shared living space, and knowing the way a person takes their tea or coffee or if they prefer juice. Remember Kelly and her response to dinner? (What happens if you have been asked by six separate staff members over two days what you want to eat? What if no one remembers what you like or don't like for meals, or you struggle to make even simple decisions? How would you respond?)

Psychological

Feelings of isolation and exclusion, feelings of loneliness, being devalued, labelled, disempowered, others' limited expectations, not having someone to listen can all result in acting out and challenging behaviour (Fitzmaurice 1982).

Angry, violent, aggressive responses can be frightening, especially if the person – adult or child – is unaware of the source of their rage. The very behaviour that they are using to defend themselves against pain, or as a method of communication to say *'hear me, see me, help me'* becomes the very behaviour that drives people further away and results in more loss and exclusion. Small steps or one piece at a time is the only way to build a foundation for significant work with vulnerable people. This is only going to transpire if we can hear beyond the words and actions to what they are really trying to convey. Dean saying 'Shut up, you're thick and you can't sing' could be perceived by the staff member as a personal insult at the thoughtfulness a birthday song and a muffin, if not viewed through the lens of a hurt, ignored child by those attuned to him. If unaware, the staff member could internalise Dean's reaction as an insult, with the result that an effort will not be made again. With recognition of the child's lived experience, a simple gesture could be viewed as a psychological hug or handshake – a feeling of being recognised, of being seen, and a special day valued. Furthermore, staff reminding the other young people in the club who made negative comments, 'Ease up, guys, remember we don't speak to each other like that here,' or, 'Well, if you want a song, just say so – I can serenade you too' not only recognises Dean and his bruised emotions but also deflects the attention from him and the extra hurt that the comment may bring to him, unintended or not. Awareness by a professional of the psychological underpinning of aggressive behaviour in this situation is not defending negative reactions or a cure-all for the possible hurt, but it is a prompt to remind individuals of expectations, allowing the person who is spilling out to have space to recover, to not lose face in front of others but also to realise that they are truly seen and understood.

Organisational

Braye and Preston-Shoot (1995) highlighted reasons for difficult behaviour stemming from the organisation itself, they voiced concerns regarding service provision in itself been oppressive, examples in practice can be limits imposed by a structured setting, by an inadequate physical environment, by an over-controlled routine, and lack of choice and freedom. At the beginning of the chapter the question was posed – how did you feel if you were not able to use your voice, if you felt unheard? Did you want to react, to hide, to freeze, and have repeated conversation in your head about what you should do? Did you want to shout, feel frustrated or angry? If the problem is down to

communication, this can frustrate the individual. Examples of these challenges could include difficulty in processing information that they are given – the information not being explained in a way that is specific and appropriate to the individual; not being able to express their feelings and difficulty in discussing issues they are worrying about; lack of control over their decisions and their independence. Unstructured time can be problematic, as can over-sensitivity or under-sensitivity to sensory stimuli.

Challenging behaviour is often a reaction to not being heard; it is a challenge not only to the staff and the service but to the organisation as a whole – to the system at large: 'Hear me, I want you to listen, I want to make you understand!' Van der Kolk (2015) outlined that in order to thrive we need relationships and opportunities to feel heard. We must move beyond the superficial conversation, but only if the place, people and system allow it. If the organisation, system or staff are felt or perceived as not understanding, not acknowledging, inflexible, the emotions, beliefs, thoughts held by a child, adolescent or adult, especially those who often feel at the mercy of a system, must escape somewhere. This fountain of emotion can no longer be held back and spills over in excessive anger, freezing or disengaging, or violent behaviour to self or others, as anger is often easier to experience than pain. You may see the organisational reasons that lead to the behaviour witnessed in Mark, Kelly and Jess ('not my own home, different adults every day asking the same questions, can't leave my things lying around, report keeping; everyone writes things down about me all the time – my whole life is a book'). Braye and Preston-Shoot (1995) advocate for 'a balance of power' in the relationship between staff and client – through self direction, respect and tolerance for the clients to participate in their own service design and delivery.

Behaviour Management Planning

The life of a vulnerable person in our care is not always an easy one and we need to recognise that all behaviour has a function, and there could be several reasons for it. The ability to see, understand and acknowledge behaviour is the opportunity to witness the child's, adolescent's or adult's inner world. Furthermore, if we are attentive, we can acknowledge that the behaviour, whether conscious or unconscious, is describing the service user's lived experience. To develop a relationship, and to offer structured supports and strategies to aid positive change, begins through learning from experiences of challenging behaviour. Managing behaviour, especially challenging and potentially aggressive behaviour, begins with a recognition of triggers and stress points.

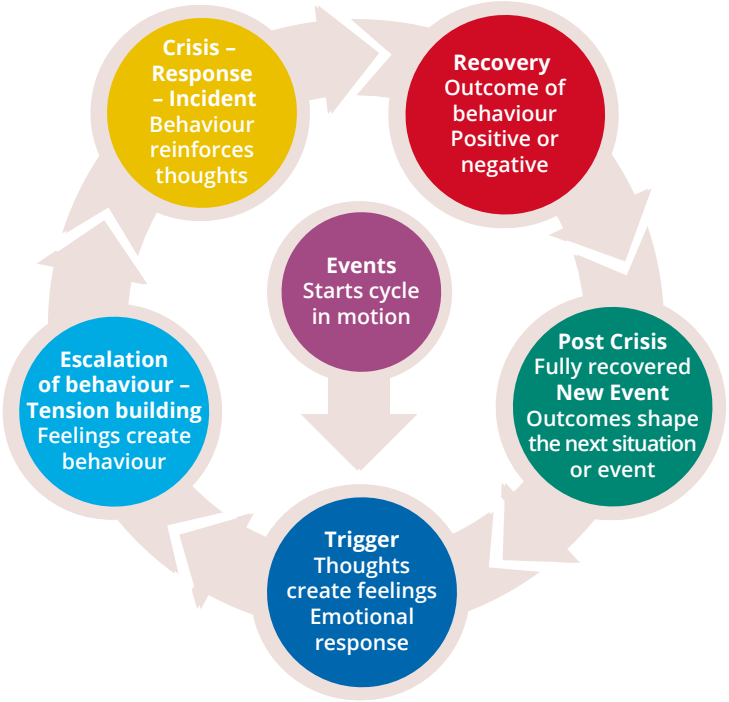
During relationship-building, look at what the person's baseline (or everyday) behaviour is like, and what they experience as triggers (things that upset them, make them angry or that they struggle with). Listen to the service user when they are calm and work with them on how to avoid future overreactions. Examine de-escalation or support strategies to help them communicate what they need us to understand. Examples of de-escalation techniques include humour, taking time out or space alone, going for a walk, having someone to talk with, or using a punchbag when they feel heightened.

We need to remember that the individual should *always* be at the centre of all interventions, as one approach does not suit everyone. The most fundamental way of ensuring this is to ask the person what works or does not work for them at a time when they are calm or when they are able to explain in their own words. 'What upsets you or makes you feel more angry or like running away?'; 'Are there things that make it worse?' Reflect for yourself what it feels like when you are angry and someone says to you, 'Calm down'. Ask the question, 'What makes you feel a bit better; do you like to be left alone or does it help to get out of the room/house?' There is always an opportunity for learning; it may be just planting the seed within the person that YOU are the one who knows best, YOU have control over this, we want to support you in learning the skills to apply what you know.

Our aim should always be to improve the individual's overall quality of life. As professionals in social care, it is our responsibility to protect the individual not only from any potential risks but also from themselves and others around them. By treating them with respect, using a measured response and working with them to understand that such behaviour is not acceptable, and a range of other appropriate communication methods *are* acceptable, you can ultimately help reduce flare-ups by helping them understand why they felt they need to act this way in the first place. Challenging behaviour can only realistically be handled with positive responses and a full understanding of the real cause behind it.

Behaviour Management Strategies

The employment of a specific approach to behaviour management by an organisation endeavours to make sure that the safest possible work practices are followed with positive consequences for the continued emotional and physical wellbeing of all the people in the organisation, staff and service users alike. But when we think about challenging behaviours and our experience of challenging behaviours, we recognise that behaviour generally occurs in a cycle which is known as the assault cycle (Kaplan & Wheeler 1983). It consists of: trigger; escalation; crisis; recovery; and post-crisis.



By using the assault cycle as an analytical tool it can support us in understanding antecedents and reasons for behaviours. It can support us develop a range of strategies to help reduce or remove the triggers that cause challenging behaviour and to teach more appropriate behaviours. It can also assist us in providing positive and negative reinforcement and consequences of behaviour that will encourage more appropriate responses. The Mansell Report in 1992 classified four essential features that would inform organisations on how to respond to challenging behaviour. These were 'prevention, early detection, crisis management and specialised long term support' (Fitzmaurice 2013: 183). This was the beginning of the development of a model of care that offers normalised, individualised and personalised support, which has been influential in the creation of the approaches and combined strategies used today.

It must be recognised that for the safety and wellbeing of all and in relation to positive role modelling within a service by staff it is never appropriate to ignore behaviour that is potentially abusive, destructive, threatening or dangerous. The decision to intervene and manage injurious behaviours requires professional judgement (Fitzmaurice 2013). The assault cycle (Kaplan & Wheeler 1983) as a system reflects the basic premise that underpins many of the therapeutic behaviour management programmes. The main ethos of all behaviour training programmes is not just avoiding and managing the situation but working with and developing life skills to aid individuals in regulating their behaviour that will have lifelong positive outcomes for those involved. There are a range of behaviour programmes for social care professionals to upskill and as part of their continuous professional development. Under the National Standards for Children's Residential Centres (HIQA 2018) and the Policies and Procedures for Children's Residential Centres (DoH 2009; TUSLA 2013). It is mandatory for all staff to complete behaviour management training, a full course initially and then a refresher course within one year.

Working with Challenging Behaviours

In working with and managing challenging behaviour, especially high-level chaotic or aggressive behavioural disturbance, social care workers may take the following into consideration:

- *All behaviour has meaning:* What is this behaviour trying to communicate? When Mark was kicking the door, saying you stole his headphones, what did he want to verbalise but was unable to? A difficult day at school? What does he feel is missing/has been taken from him? Does he need some individual attention? The *Therapeutic Crisis Intervention Handbook* (Cornell University 2012: 27) asks, 'What does this person feel, need or want?'
- *Timing:* Always try to intervene at the escalation of the behaviour to offer strategies for the person to vent the emotion, discharge the feeling in a manageable way and return to baseline before the situation gets out of hand, e.g. 'Mark, you sound and look really upset and angry, can you tell me why?' or 'Come on, will we go kick the ball in the garden and we can chat?' Or in response to Dean, 'I'm aiming for the next season of *The Voice* but while I'm practising my act will you take out the cups and we can have a cuppa to go with your birthday muffin?'
- *Read the environment and the situation at hand:* Early intervention can often stop escalation. Review the people, the situation and the environment. If the situation may calm down, leave it alone and do not interfere. All individuals need to find a way to regulate and mange differences with others. However, also read the room: was there an antecedent that has resulted in the person's behaviour beginning to escalate, or is the person still becoming heightened, e.g. pacing, fidgeting, foot tapping, muttering under breath? (Think of Jess returning from being missing in care, the potential impact of her being reported missing, the possible consequences for her, fear of reprisal. This may need intervention to prevent the situation developing.) Choose the time, place and moment to intervene; the main focus is safety and aiding a return to baseline behaviour. Consequences for actions and process work can be done at a time and in a space that is right – which may not be right now. 'Jess, it's very late and we're all tired. We can talk about this tomorrow – for now let's get you sorted and get a good night's rest, we'll figure it out together tomorrow.' If necessary, distance yourself physically from the situation. This is not an admission that you are not able to manage the situation, but being astute and intuitive enough as a social care worker to recognise that this is not the correct time. Active engagement around an emotive topic now may be more detrimental than helpful in the long term.
- *Conscious use of self:* Asking yourself 'How do I feel now? What are my thoughts?' might seem impractical when a situation is becoming difficult, but taking a second to check in with yourself may prevent a situation from becoming more uncontained (McDonnell 2010). As practitioners it is fundamental to be able to read our own internal responses to a situation, acknowledge our own

emotions, reaffirm our ability to manage the situation and be aware enough to know when more support is required. Even though the content may be channelled at you, the motive behind it is not usually you. Instead, it is related to the person's prior experiences and how something has resulted in them being triggered, and their inner child is reacting in the only way they know how – fight, flight, freeze. If we are not attuned to this, how might we respond to a distressed person? Our tone of voice might be too sharp if we are irritated or tired; we might interrupt, use too many words or name consequences because we feel threatened or anxious; we might blame the person for the consequences; our body language might be unhelpful, e.g. staring, showing defensiveness by crossing our arms, putting out our chest, raising our voice to make our point?

- *Awareness* of the value of relationship and the individual's strengths, challenges, trigger points and baseline behaviours (Kemshall *et al.* 2013). Familiarise yourself with the individual's crisis management plan (ICMP) or behavioural support plan. Consider which tool to use at that particular moment to allow the person time to pull back, to deflect the agitation or reduce tension, e.g. humour, just being present with, ignore, etc. With Kelly, you might ignore the interaction with the other resident and return to it at a later time, and use encouragement and humour – put on an apron, use the chef's voice from *Sesame Street* or tell her dinner is going to be a game of 'Come Dine with Me' or the 'Blind Taste Test' – you cook and the young people must guess what it is, those who guess correctly winning a takeout night. Intuition might tell you that the individual may need particular attention at that moment but is seeking it in a negative way.
- *Kinesthetics:* Body language, eye contact. How you approach a situation, the tone of your voice, your language and body language are crucial factors in helping or hindering (McDonnell 2010). For example, 'I want to talk with you' could be construed as 'trouble'; having other people around as an audience can impede the work. Visualise Kelly – she may feel that she cannot be seen to 'give in' to staff. Ask the second young person if you can have a moment with Kelly, sit beside or in proximity to her (being in front of a person can often be viewed as too confrontational), use a low, gentle tone of voice, make eye contact if possible, but vary eye contact (staring can be disconcerting), and ask open questions – 'What's happening at the moment?' – or 'door openers' such as 'What's up?' – which require more than a yes or no answer (Cornell University 2012).
- *Ignore or redirect:* On occasion a behaviour is best dealt with at that moment by the simple expedient of ignoring or redirecting it. You might choose not to engage Kelly at that particular moment in relation to her behaviour around dinner or you could offer alternatives, e.g. you will do 'pick and mix' for dinner, but does she want to get her chores done before or after the meal? With Jess you might say, 'Well I'm sure it would hurt very much, Jess, getting cut with a knife, but imagine the blood – red is not my favourite colour' or ' I'm going to have a toastie, would you like one? Would you butter the bread?' or 'It's late now and you must be tired, we can chat about this in the morning.' This is not ignoring the behaviour but offering space to rethink the situation as needed, and calming the environment; you can return to the event and reflect on it at another time when there is the opportunity to spend time processing the reasons for it, its impact, what could be amended (Briggs 2002).
- *Distraction:* Can you change rooms, or get some other activity going that will minimise the emotion in the situation and support the person to regulate? Diverting the individual's attention elsewhere in the preliminary stages of a behaviour that challenges by focusing on other movements, environments, activities, can defuse tension. For example, with Jess: 'Do you want to take a shower or get into some comfortable clothes?'; with Mark: 'Come on, I'll help you look for your earphones, I'm sorry they're missing, but don't worry, we'll hunt them down' (CMHCM 2012).
- *Silence:* Not every silence needs to be filled with noise, if appropriate, sit with the emotions, allow the person to vent and your presence alone will be enough. Sometimes people need time to process their thoughts or think out loud or have a sounding board. If needed, reassure the person that you are there and you are listening to them – 'I am here for as long as you need.'

- *Alternatives and directives:* Many people, when caught up in emotion, become 'stuck' in the fight, flight, freeze loop. They may be unsure what to do or be unable to consider other rational alternatives to acting out or how to extract themselves from the situation. Consider what choices are available and what method best fits the person – remember, individuals are key. Some service users will respond to direct language, short, concise and direct, e.g. Dean – 'Please move back from …'; Mark – 'Please stop kicking the door.' Other situations and persons may be best met with options – offering a choice but also giving back a sense of control. Offer limited choices; too many will add more turmoil, e.g. with Mark, 'I can see you're upset. We can do two things – one, let's go look for the earphones together now; or two, come into the garden and we can figure this out together.'
- *Compassionate movement:* This is not a reinforcement of negative behaviour but a recognition of the person and their distress. Assess whether this is appropriate or could escalate the situation more. Any physical touch is dependent on your relationship, your experience of the young person and their history. Approach the person from the side, not the front, as it is less confrontational, sit down as opposed to standing when chatting with them. If the situation is between two young people, can you sit or stand between them as a buffer? A hand on the forearm or shoulder can be enough to say, 'I'm here and I am holding you (metaphorically).' Remember, physical touch is completely dependent on the person's wishes and level of distress at the time. It should never be used when a person is moved beyond irritated and agitated and very heightened (Cornell University 2012).

As professionals in social care it is important to recognise that all attempts to manage challenging behaviour must happen in the context of duty of care to both the vulnerable people and the staff with whom we work. Management of challenging behaviour, whether it is mild, moderate or severe, must take into account the personal attributes of the vulnerable person based on a needs assessment of the physical and social environment in which the person's care takes place. All challenging behaviour is communicative and happens within a social context: *it always has meaning*. As social care workers we need to always remember that the service user can be helpless and vulnerable to exploitation and harm, therefore special attention needs to be paid to managing respectfully and safely the challenging behaviour presented by the individual and understanding what they are trying to communicate to us.

As social care workers we also need to acknowledge that the effects of working in crisis situations every day can be arduous and demanding. Continuous professional training, personal supports through a team system and reflection through professional supervision is vital in helping us to identify and cope with the personal and professional challenges implicit in this often highly stressful aspect of social care practice. By acknowledging our strengths and vulnerabilities and through mutual respect, planning effective, consistent strategies together will support us in working and responding appropriately and in respecting individual differences within our professional team and with people with challenging behaviour (Fitzmaurice 2013).

TASK 4

- Be a self-reflective social care practitioner. What behaviours are you at ease with? What behaviours challenge you most? Can you consider why?
- Review one previous event in relation to a difficult behaviour you experienced. How did you handle it? What went well or perhaps what did not? What could you do if it happened again?
- Be creative. Look at the interests of vulnerable individuals and recommend activities that are enjoyable that could be used as an antecedent to a behaviour.
- Choose a service user who has challenging behaviours and look at friendships. Recommend activities using a 'buddy systems' approach where s/he supports another service user in the activity or another service user supports them. Observe them together to see if they regulate their own behaviour or each other's behaviour and identify if they find this behaviour management easier or less conflicting than with a staff member.
- Study the management approaches used by the organisation and examine how they are realised in the services Challenging Behaviour Policy.
- Make a time in the day where everyone within the service can sit down together to share a challenge or a pleasurable experience of their day and discuss how it made them feel.

Tips for Practice Educators

A founding requirement for the achievement of this proficiency is the student being able to recognise all behaviour, including challenging behaviour, as a form of communication and demonstrate an understanding of the underlying causes in order to apply appropriate strategies.

- To help a student comprehend behaviour as communication, ask them to describe a recent experience when they felt they were not heard or could not communicate their point, how it made them feel and how they reacted to this experience.
- Then encourage the student to talk with a service user about how they communicate their feelings to the staff and what type of communication method is the most beneficial to them in their lives. If the student is working with service users for whom verbal communication is challenging it might also be useful for them to talk to staff and gain assistance in adapting to the service users' communication techniques.

As well as understanding that all behaviour is communication it is also important that the student has a level of self-awareness about what to them constitutes challenging behaviour.

- What are their own comfort limits in relation to experiencing or dealing with challenging behaviour? We must be aware of our own boundaries and limitations in order to support others to learn theirs.
- Additionally, for practice educators an intellectual understanding of challenging behaviours in social care and the main forms and multiple factors that underlie challenging behaviour is essential. If social care workers do not have a grasp of the root of behavior, we cannot anticipate the events that may be triggers.

Having the conversation and asking the student to explain it from a factual/theoretical experience first and then to give examples of challenging behaviors practically – where they observed it and how it was managed – will allow you to informally assess the link between the student's understanding of challenging behaviour and their observations on the behaviour management strategies used by the organisation. Remember, because of the complexity of challenging behaviour and the professional judgement by staff on how a behaviour is managed, for example when a behaviour is ignored, redirected, averted or reported on for assessment by a specialised team, can be confusing, so you may need to guide the student through this multiplicity of decisions on challenging behaviour cases. If a deficit in the student's understanding is identified, you can either direct them to review knowledge they encountered in their academic study or provide them with reading material associated with challenging behaviour. It is imperative that you provide a time frame in which you will follow up on the reading, thus creating a cyclical learning relationship between task ascription, task completion and professional development.

Once the student can converse about the multiple factors that underlie challenging behaviour and how it is used as a communicative mode, you can ask them to consider the challenging behaviour management method used within the service and the strategies they have observed staff use since beginning placement.

- You could ask the student to personally reflect on their concept of challenging behaviour and how it might inform or challenge their practice as a professional and the experience of the vulnerable service user. While potentially uncomfortable, it is important that this analysis happens so the student can use in-action reflection, thereby maximizing the opportunity for service user support, respect, safety and care.
- An aspect of professional practice the student needs to adapt to is the responsibility to adapt practice, so that service users experience a high level of support through the means of their individual communication methods.
- As the student grows in confidence it is important to encourage them to identify activities that could potentially support the prevention or aversion of a behavioral outburst and to discuss them with the key staff working with specific vulnerable individuals.
- Within supervision these opportunities could be considered in terms of viability and included in the service users' personal behavioural plans or in the organizational strategy.

Part of analysing activities is to identify if they are feasible, useful and relevant to specific individuals – has the student observed and accurately interpreted the service user correctly?

- The student may provide suggestions and creative activities, but it is not the student's responsibility to enact these activities**.**
- Ask the student to create a picture communication booklet with a service user (or group) that represents the service user's interpretation of feelings and emotions when communication is acceptable and they feel heard **or where** they felt frustrated where they feel not listened to and misunderstood. The booklet should include activities that promote positive behaviour and that help with behavioural balance, and strategies to support or regulate the behaviour. **This could be fruitful as a means of increasing the student's awareness of the proficiency or a way to demonstrate their capacity to enact the proficiency.**

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