Guide to the Standards of Proficiency for Social Care Workers

Domain 5

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.

Sharon Claffey qualified as a social care worker in 2020 with a BA (Hons) degree from Institute of Technology Carlow. She has practice experience in childcare and recently in the homeless sector. She has experienced many different areas in this sector, for example family hubs, all-male hostels and residential care. She has also completed an internship in IT Carlow, where she worked in the placement office for ten months. She was an active volunteer throughout her time as a student and has volunteered with Le Chéile (Mentoring and Youth Justice Services) for four years to date.

Paul Creaven graduated from Limerick Institute of Technology in 2015 with a first class honours in Applied Social Studies (Social Care). Since then Paul has worked in services that support people diagnosed with acquired brain injuries, strokes, autism spectrum disorder, physical and sensory disabilities and mental health. As well as working in diverse service settings Paul has worked on projects in accessibility, has been a local co-ordinator of a national audit by the Commission on Accreditation of Rehabilitation Facilities (CARF), a certification co-ordinator with ETB and QQI frameworks in vocational and day services, and a fundraising co-ordinator; has supervised students on placements and provided presentations to businesses, schools and colleges on awareness of acquired brain injuries, strokes and services. Paul is now a community service manager in Rehab Care in Galway, where he has been working since early 2019.

Niamh Delany has seventeen years' experience as a social care worker in services supporting people with intellectual and psychosocial disabilities. She holds a master's in International and Comparative Disability Law and Policy and is passionate about the implementation of the United Nations Convention on the Rights of Persons with Disabilities. Throughout her career Niamh has advocated for and empowered decision-making and choice using person-centred planning. She serves as Independent Chair of the Peamount Healthcare Equality and Human Rights Committee. Niamh offers quality improvement and regulatory support consultation to organisations providing services for people with disabilities. She is an active member of Social Care Ireland.

Helena Doody is a social care worker in education and Head of the Department of Humanities in Technological University Dublin, Tallaght Campus. Helena has over thirty years' experience working with marginalised groups and individuals. During this time, she has worked in the social care sector as social care worker, social care leader and co-ordinator of services. She has a passionate interest in advocacy, equality and issues regarding access to higher education, which is the topic of her current doctoral research. Her experiences to date have provided her with a multi-lens view of the systemic inequalities that exist in society from both the social care front line and academia. Helena is currently on the Board of Directors for Social Care Ireland.

Laura Doyle, who is a social care manager employed in a service for adults with intellectual disabilities, graduated with a BA (Hons) in Applied Social Studies in Social Care in 2012 from Waterford Institute of Technology and worked as a social care worker for a number of years supporting adults with disabilities. Laura currently supports a team of social care workers in the provision of high-quality services and supports in a day service setting. Laura is also a PhD student in Waterford Institute of Technology, undertaking a research project on 'Moving towards a human rights-based approach in disability services: An analysis of social care workers' skills and competencies, which explores how policy manifests into social care practice.

Francis Gahan qualified as a social care worker with a BA (Hons) in 2013. He has practice experience in disability service provision and residential childcare. He holds an MSc in Applied Social Research from Trinity College Dublin and is currently undertaking PhD research at Technological University Dublin. He also continues to work on the Applied Social Studies (Professional Social Care) programme at Carlow College, St Patrick's, where he attained his undergraduate degree.

Sarah Joyce currently works full time in frontline homeless services. She has extensive experience in numerous challenging environments from homeless services, education centres and direct provision centres to addiction services, dealing with people from a person-centred perspective. She holds a BA (Hons) in Social Care from Technological University Dublin.

Antonia Kenny is a social care worker currently teaching in Moate Business College in the School of Caring. Prior to this, Antonia worked in Rehabilitative Training and lectured across the Humanities Department in the Institute of Technology Carlow. Antonia has also worked in residential care and day service settings for people with disabilities and is a committee member of the Social Care Ireland Disability Special Interest Group. She completed her MA in Health Promotion in 2017 with the National University of Ireland, Galway, focusing her research on the barriers and facilitators to social inclusion for people with intellectual disabilities. This research was published in the Scottish Journal of Residential Child Care in 2018.

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).

Lindsay Malone is a social care worker in education and is the Deputy Head of Faculty of Lifelong Learning at Institute of Technology Carlow. She has spent the last number of years as an associate lecturer teaching across BA and MA programmes. Lindsay has held senior management roles across both the voluntary and community sector and the private sector. She is currently undertaking a PhD in Education and Social Justice at Lancaster University. Lindsay was previously a director with the Gaisce National Council and is a fellow and mentor with the Irish Institute of Training and Development (IITD).

Victoria McDonagh is a social care worker with over twelve years experience in both Ireland and Australia. She is currently a lecturer in Social Care and Early Childhood Studies in Waterford Institute of Technology. Victoria has worked with a wide range of service users in the areas of family support, mental health, dementia care, chronic illness and disability. She has also worked in management, leading social care teams and programmes. Following her degree in Social Care, Victoria has completed postgraduate study in Family Therapy and a master's in Child, Youth and Family Studies. Victoria is passionate about empowering service users to reach their full ability as well as providing person-centred support. She is also active in research in social care and early childhood.

David Power has an MA in Management, a BA (Hons) in Social Care, a BA in Applied Social Studies, a National Certificate in Vocational Rehabilitation, a diploma in Education and Community and a diploma in Employment Law. He was President of the Irish Association of Social Care Workers (IASCW) and one of the founding members of Social Care Ireland Executive. He has represented the profession on the Health and Social Care Professionals Council for eight years. He has over 34 years experience in the provision of services to the most vulnerable people in our communities (including with the Children Detention Schools, the Crisis Interventions Service, Community Care HSE) and is now the Director of the voluntary agency Smyly Trust Service.

Noelle Reilly is a social care worker currently working as social care placement co-ordinator and associate lecturer in Institute of Technology Carlow. Noelle has extensive experience as a social care worker in Ireland and has worked in residential care and in the disability sector. Noelle is currently a member of Social Care Ireland and is an active member of the Irish Association of Social Care Workers and a member of the Social Care Workers Registration Board.

Juliane Reinheimer is an experienced social care worker and has worked with people with intellectual disabilities in St Michael's House since 2003. She spent several years in Germany, in Castletown Bearhaven psychiatric hospital, has worked in Co-Action and has volunteered in the Darndale Life Centre. As well as a social care degree from the Open Training College, Juliane completed a diploma in Public Relations at Griffith College and has an LLM in International and Comparative Disability Law and Policy from the National University of Ireland Galway.

Padraig Ruane is a social care worker currently working with the National Advocacy Service as a disability advocate. Padraig graduated from Dublin Institute of Technology in 2009 with a degree in Social Care. He has experience in disability services, individualised services and for the past six years has been working in the area of advocacy.

Christina Sieber is a social care educator currently working as the Professional Practice Co-ordinator for Social Care with Institute of Technology Carlow, Wexford Campus. Christina completed a master's in Social Care at Cork Institute of Technology in 2005 and a master's in Teaching and Learning in the Institute of Technology Carlow in 2018. Christina worked in the field of social care for nineteen years in mainstream residential care before taking up her current post with IT Carlow. She has been an associate lecturer with IT Carlow's Life Long Learning department on the Social Care course since 2015 and has supervised many students completing their dissertations at both degree and master's levels. Christina's main interests are in the area of reflective practice and the correlation between reflective practice and critical thinking.

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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 62 – Sarah Joyce

Domain 5 Standard of Proficiency 1

Know, understand and apply the key concepts of the domains of knowledge which are relevant to the profession.

KEY TERMS

Relevance to Profession

Domain 1: Professional Autonomy and Accountability

Domain 2: Communication, Collaborative Practice and Teamwork

Domain 3: Safety and Quality

Domain 4: Professional Development

Domain 5: Knowledge and Skill

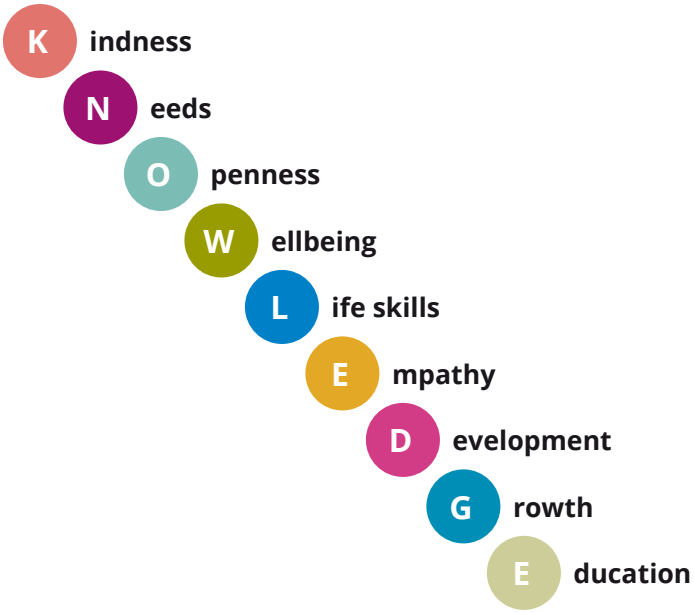
Social care is … understanding what people meant when they said 'find a job you love and you will never work a day in your life'

Relevance to Profession

This proficiency recognises that all the domains work in tandem with each other and therefore our knowledge/skill set as practitioners must encompass all domains. This is achieved, first, by understanding each domain and its related proficiencies and, second, being able to relate the relevant skills/knowledge to those proficiencies in a professional setting. While each domain has an allocated number of proficiencies it also has a key concept running through it. For example, in domain 5 the key concept is the knowledge and skills within the social care profession. For the purpose of this chapter I will be relating my points back to working within the homeless sector.

Knowledge in the social care sector is a vast area. It can refer to academic knowledge gained through studies, for example using case studies to learn about unique behaviours. Knowledge can relate to life experience gained outside a lecture hall, for example visiting a client in their home and being able to turn the power back on after a switch has tripped. Social care involves using life skills and knowledge to work with people in order to enhance their lives and support them.

The five domains of the CORU proficiencies are individually unique, yet all are equally relevant to the core of the social care sector. The domains encompass everything that falls under the umbrella of social care. As such, it is vital that all social care workers have a clear understanding of each domain and its relevance to their chosen profession. In college, students learn the knowledge related to social care; on placement they see how this knowledge impacts on practice. The knowledge we have as social care practitioners is what underpins our practice – we make informed decisions based on our knowledge of the sector. It is vital to note that we are always learning and gaining additional knowledge; this is what allows for continuous professional development and development within the sector.



Domain 1: Professional Autonomy and Accountability

Social care focuses on working with people who are often on the fringes of society. Often the client base includes some of society's most marginalised and vulnerable people. As a result, it is imperative that we as social care practitioners build strong, meaningful relationships with the clients in our care. Positive, meaningful relationships are the very essence of social care. This is what brought a job that was once viewed as a vocation to a professionalised standard. There is always going to be a need for care within society. However, with that care comes responsibility and the requirement to be accountable for one's actions, both personally and professionally. Practitioners must understand their organisation's policies and procedures, and know how to address poor practice (Lalor & Share 2009).

It is important to be able to differentiate between the knowledge we gather as practitioners and the knowledge we share as practitioners. For example, when writing a report, it is imperative that the report is clear, factual, and relevant. 'Would it stand up in court?' This is an honest question all social care practitioners must ask themselves. 'Would you be comfortable reading out what you wrote in front of the person in a courtroom? That is the level of factual report-writing required from social care workers.

The need for autonomy and accountability within social care stemmed from past failings in the sector: the clerical sexual abuse scandals; failings in the disability sector; failings in childcare; and the current homeless crisis. When there is no one to hold accountable it can be detrimental to the victims (Jones & Carston 2016). This is why we must strive for professional autonomy and accountability and ensure that the highest standards are fostered throughout the social care sector.

Domain 2: Communication, Collaborative Practice and Teamwork

The key concept of teamwork is to achieve tasks that an individual could not. A team encompasses the skill set of all members and results in combined productivity. Within social care, work is often carried out by multidisciplinary teams and it is crucial that there is effective teamwork as each member plays a vital role (Reeves *et al.* 2011). An example of clear communication within a team is the shift planning meetings often carried out in residential services. When the new shift comes in, there is generally an oral handover followed by a shift planning meeting. The meeting sets out clearly defined goals for the coming shift. It also offers role definition to all incoming staff so they are clear on what they are required to do. This allows for clear communication of what is needed from the staff team.

Social care can be a challenging sector and often one person simply cannot meet all the needs that service users present with. Interagency collaborative practice fills that gap, for example homeless organisations working with medical teams to deliver high-quality care to residents in their hostels. The Safetynet service in Dublin City is a medical charity that delivers care to those marginalised in society and without access to healthcare, including homeless people, drug users and migrants. It also facilitates a network of health services working with homeless people to ensure a co-ordinated approach and promote best practice. It works in conjunction with homeless organisations to achieve this. In-reach services are provided across hostels in Dublin, and the Safetynet bus provides outreach services in Dublin City in the evenings. A full list of its services can be found on its website www.primarycaresafetynet.ie.

Follow this link to read an example of how Safetynet supported a person and her partner to exit homelessness: https://www.irishtimes.com/news/social-affairs/stigma-of-homelessness-they-couldn-t-hide-the-disgust-on-their-faces-1.3646825

TASK 1

Q. How can social care practitioners educate others in order to remove the stigma attached to homelessness?

Divide the class into groups. Can each group come up with four other agencies (either real or imagined) that would provide beneficial in-reach/outreach to homeless services? Use the headings Mental Health; Physical Health; Addiction; and Emotional Wellbeing.

Domain 3: Safety and Quality

The social care sector encompasses a widely diverse cohort of service users, including people with disabilities, older people, children and families, people experiencing homelessness, people in addiction, and people experiencing mental health difficulties. The common theme is that all of them need help and support from social care workers. It is imperative that this help and support is provided in a safe environment. If it is not, it could lead to additional difficulties being introduced into the lives of people in an already challenging situation.

The Irish Association of Social Care Educators define social care as 'a profession committed to the planning and delivery of quality care and other support services for individuals and groups with identified needs' (Lalor & Share 2013: 21).

Case Study 1

'Maeve' is a social care practitioner working in a low-threshold day service in a homeless organisation. Low-threshold refers to minimal conditions being placed on clients and meeting clients where they are at. It works in conjunction with a harm-reduction approach when dealing with people using drugs. When working with low-threshold clients, practitioners are often 'responding to a variety of complex needs namely chaotic drug use and associated risky behaviours; homelessness; complex physical and mental health issues and previous challenging backgrounds and emotions' (Morton & O'Reilly 2016: 16). As part of her training, Maeve has completed harm-reduction training in order to be able to use these techniques when working with clients. She has also completed Naloxone training. Naloxone is a prescription medication used to reverse the effects of opioid drugs. It can be injected or used in nasal form. In the day service, there are strict procedures to follow when dealing with an overdose. These procedures are designed to ensure the safety of the person who is experiencing the overdose, the other service users present, the staff, and any external emergency personnel.

One of Maeve's key clients is 'Mick'. Mick has a heroin addiction and regularly presents to the service affected by heroin. Maeve has been working with Mick for over a year and has built a positive working relationship with him. Mick likes working with Maeve and trusts her judgement. They are currently waiting for a detox bed to become available for Mick.

One day Mick presents to the service heavily affected by heroin; he is not responding to Maeve. Maeve directs Mick to the couch in the communal area and gets him to sit down. Staff remove the other clients from the area to allow privacy. Maeve checks Mick's breathing (number of breaths per minute). Mick's breathing is low and the emergency services are called. Maeve puts on gloves and administers Naloxone while on the phone to the emergency services as they talk through the procedure with her. The needle is then placed in a sharps bin and secured. Maeve directs staff to the front of the service to look for the emergency services and direct them to the entrance. As Mick begins to come round, Maeve calmly explains where he is and what has happened. The ambulance personnel arrive and staff lead them to Mick. Maeve has printed off a sheet with Mick's medical information, including what medication he is on, and any medical conditions he has, for the ambulance personnel. Mick leaves with the ambulance personnel to go to the hospital, where he will be fully assessed. Maeve debriefs with staff after the incident.

TASK 2

In pairs, discuss how Maeve ensured that safety standards were followed when Mick was experiencing an overdose. How did Maeve provide quality care to Mick throughout his overdose experience?

Domain 4: Professional Development

Social care is an ever-evolving sector and as a result it is essential that social care workers avail of ongoing continuous professional development (CPD). CORU defines CPD as

'The means by which health and social care professionals maintain and improve their knowledge, skills and competence, and develop the professional qualities required throughout their professional life' (CORU 2013: 11). This definition highlights the importance of CPD in the social care sector.

One effective tool for professional development is supervision. Supervision is a safe area for social care practitioners to discuss any issues or difficulties they are facing and receive the support they need. Research has shown that quality supervision results in 'job satisfaction, commitment to the organisation and retention' (Carpenter *et al.* 2017: 1). CPD, combined with effective supervision, can help social care workers through any difficulties they may face in their role. A study carried out by Social Care Ireland into workplace violence in 2016 made a number of key recommendations for future practice, including providing regular professional supervision in a suitable setting, and recommendations for social care workers to engage in CPD. The importance of regular training was also highlighted (SCI 2020).

Domain 5: Knowledge and Skill

The professionalisation of the social care sector stemmed from a need to ensure that all social care workers have the highest standard of knowledge and skills required to work in a professionalised environment. This knowledge and skill set is acquired throughout the degree, primarily in a classroom setting; it is then put into practice during placement and refined in the workplace after college. Knowledge is the ability to understand a concept; a skill is the ability to use that knowledge by applying it to a concept (Given *et al.* 2008).

Case Study 2

'Michael' is a third-year social care student on placement in a homeless service. As part of his studies he has undertaken modules on both mental health and suicide. Michael feels he has a wide span of knowledge on both topics. His placement offers him the opportunity to complete applied suicide intervention skills training (ASIST). Michael accepts the offer of the two-day training course. The ASIST training teaches suicide first aid skills to practitioners; it also trains participants to reduce the immediate risk of a suicide and increase the support for a person at risk. It helps them seek a shared understanding of reasons for living. The workshop provides opportunities to learn what a person at risk may need from others in order to keep safe and get more help (HSE 2020). After completing the training course Michael has the skill set and the knowledge to help someone presenting with suicidal thoughts and/or behaviours. He feels confident that he would know how to reduce the immediate risk to the person to keep them safe in that moment.

TASK 3

Can groups display an understanding of each domain using only pictures?

While skills and knowledge can be attained, the personal factor is far more innate to the social care worker. The importance of building and maintaining relationships within the social care sector is at the very core of the profession. This is what brings the skills and knowledge to life. It is the realisation that a person not only has the ability to help and support, but also the willingness and kindness that is imperative when dealing with vulnerable and marginalised people.

Tips for Practice Educators

Use the online Kahoot game (an online tool that allows lecturers to set quizzes for students: https://kahoot.com) to set a quiz for the class based on the key concepts of each domain.

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Chapter 63 – Juliane Reinheimer

Domain 5 Standard of Proficiency 2

Understand and be able to apply principles of social justice in one's work including being able to challenge negative discrimination and unjust policies and practices; demonstrate an understanding of cultural competence; and work towards social inclusion.

KEY TERMS

Social justice
Negative discrimination
Unjust policies
Cultural competence
Participation

Social care is … when the social care worker uses passion, empathy, activism and resilience to fight for social justice for the people they support.

The focus of this proficiency is on understanding and applying a social justice approach to social care practice. Social care workers work in disadvantaged and marginalised communities within society, who include people with disabilities, older people, people from the Traveller community, children, women and young people. For these marginalised groups, achieving social justice will be a continuous, ongoing struggle because they face barriers such as outdated laws and societal attitudes. The realisation of the Assisted Decision Making (Capacity) Act (DoH 2015) in Ireland demonstrates this very well. Arguably, change is slow; however, with awareness and knowledge, social care workers can promote a more socially just experience for the people in our care. This chapter applies the proficiency to social care services for people with intellectual disabilities, but the information presented here is relevant to all social care settings.

Introducing Social Justice

Social justice can be understood through the four principles of **access**, **equality**, **rights** and **participation** (Adams & Bell 2016), which are explained in the following table.

Access	This reflects the hierarchy in society, where some groups have resources, status and privileges that are denied or rationed to others (Adams & Bell 2016: 33).
Equality	As well as being fair to everyone, equality is a *'commitment to social justice'* which *'requires a moral and ethical attitude toward equality and possibility, and a belief in the capacity of people to transform their world'* (Adams & Bell 2016: 42).
Rights	Our basic human rights include access to food, safety, a home, a living wage; and in addition *'civil rights of educational equity, immigration reform, redistribution of wealth, and against different forms of violence, including hate crimes, violence against women, and police brutality against men and women of colour'* (Adams & Bell 2016: 164).

Participation	*'Our vision for social justice is a world in which the distribution of resources is equitable and ecologically sustainable, and all members are physically and psychologically safe and secure, recognized, and treated with respect. We envision a world in which individuals are both self-determining (able to develop their full capacities) and interdependent (capable of interacting democratically with others)'* (Adams & Bell 2016: 26). This statement encapsulates what is means to participate fully in a life of choice and access.

Social justice is the practice of active empowerment, enabling everybody to exercise their human rights. In broad terms, social justice magnifies and explores the relationship between the individual and society by questioning if this relationship is fair and just. Additionally, social justice acknowledges the fact that external influences can have an impact on our health and wellbeing, access and ability to exercise our rights in society.

TASK 1

Think of one service user group and give examples of how the four principles of access, equality, rights and participation of social justice may be relevant to their lived experience.

Congregated Settings

'Over 4,000 people with disabilities in Ireland live in congregated settings … a residential setting where they live with ten or more people' (HSE 2011: 10).

The place where a person lives can also contribute to the social injustices they experience, and one example is residential care settings for adults with mental health issues and/or intellectual disabilities. Irish journalist Mary Raftery exposed our past failings in a two-part RTÉ documentary series entitled *Behind the Walls* (Raftery 2011). This programme highlighted the many abuses that took place in mostly Church-run mental health institutions in Ireland during the 1940s, 1950s and 1960s. Large institutional services were abolished and people with an intellectual disability were moved to smaller congregated settings.

According to Parker and Clements (2012: 24), 'an institution is not defined merely by its size' and the fear with all small congregated living community-based spaces is that they can function as 'mini-institutions' if residents have no choices or control over their lives (Fox 2013). There are practices currently in place in residential services for people with an intellectual disability to help with the transition from a larger institution to their community-based home. This is part of the New Directions policy and the National Disability Strategy to promote 'large scale national change', inspired by the principles of social justice (HSE 2009: 26). However, resources are needed to support organisations to become more community-based with services and buildings that are more open and inclusive, to help service users access community services and facilities. The situation is not perfect and service users may have to live with people not of their choosing, or have their placement changed due to ongoing funding issues or a lack of suitable accommodation. It is professionally challenging to provide hope to service users who have been moved, or who cannot exercise their choice of living companion or accommodation.

TASK 2

Please watch *Behind the Walls*, Parts One and Two, available on YouTube: https://www.youtube.com/watch?v=9SkBvTUXN2U and https://www.youtube.com/watch?v=WXtdq1yq1HA.

Negative Discrimination

Negative discrimination is experienced when a group or an individual is treated poorly or is oppressed by another person or group. In Irish law there are nine recognised grounds of discrimination: gender, civil status, family status, sexual orientation, religion, age (except if a person is under 16), disability, race and membership of the Traveller community (O'Duffy 2018). It is worth mentioning that discrimination can occur on more than one ground, they can overlap, and this is known as 'intersectional' discrimination. This is the case when various characteristics 'intersect' and amplify the experience of discrimination. For example, a woman might be discriminated against not only for her gender, but also because she is a member of the Traveller community, because she is a single mother and/or because she has a hearing impairment. O'Duffy (2018: 11) asserts that discrimination can also be direct or indirect. Direct discrimination relates to experiences 'when a person is treated less favourably because of who they are' and indirect discrimination occurs when a rule (this could be a policy, for example), which might be seen as fair, puts a person at a disadvantage on any of the above listed grounds, based on its impact or consequence.

Unjust Policies

An unjust policy could be an unfair rule which might be directly or indirectly discriminatory. Public policy affects us all profoundly and pervasively and can influence every aspect of our lives. A public policy is a rule that guides the way services are distributed or interact with individuals. Public policies are usually determined by governments in consultation with stakeholders and have a direct impact on the way services and supports are provided. Each area of social care work is impacted by policy at various levels and to a greater or lesser extent. As social care workers, it is important to be aware of unjust policies. An 'unjust policy' could be, for example, a policy in a community house that the residents are not allowed to have friends over, or that people with intellectual disabilities are not allowed to get married or enter sexual relationships. It is important to note that this is a complex issue and although some policies may appear unjust, they may be written with safety in mind. With an awareness of amending unjust policies and reducing risk-averse practices, services are moving towards positive risk management.

TASK 3

Review Inclusion Ireland's website (https://inclusionireland.ie) and discuss the recent positive developments that reflect a move towards social justice practice.

Cultural Competence

Rhonda Livingstone highlights that cultural competence is based on our motivation and action to create understanding between people, and to be respectful of different cultural perspectives (DEEWR 2010). Relationship building is fundamental to cultural competence. This is based on providing strong foundations of understanding about each other's expectations and attitudes, values and beliefs. Underlying cultural competence are the principles of trust, respect for diversity, equity, fairness and social justice. '*Culture is the fundamental building block of identity and the development of a strong cultural identity is essential to an individual's healthy sense of who they are and where they belong*' (DEEWR 2010: 21).

Social Inclusion through Person-centred Planning

Social inclusion is as a universal human right. The aim of inclusion is to embrace all people irrespective of race, gender, disability, medical or other need. It is about giving equal access and opportunities and getting rid of discrimination and intolerance (removal of barriers). It affects all aspects of public life. Social inclusion is visible through the process of individual planning and designing the service to meet the needs of each service user, irrespective of race, gender or disability. In my professional experience, individual planning is now replaced with 'person-centred planning'. To ensure this does not become a 'box-ticking exercise' it is important that adequate time is provided to meet with service users, work with them in a meaningful way and explore their true needs and wishes, along with identifying their support circle. Service users may feel ambivalent towards this process, especially if the experience feels more like an 'assessment'. It is essential to develop a relationship with the service user before engaging in person-centred planning to encourage information sharing that is not perceived as too personal and invasive and is respectful of the individual's right to privacy and choice. It is also important to be aware of the culture within the service, and the physical environment, to ensure that every service user feels included.

As stated by McConkey and Ryan (2001), staff have significant power and influence when it comes to the lives of people with intellectual disabilities in residential services. It is important to note that this influence occurs both consciously and unconsciously through daily interactions. Organisational policies, the political landscape, domestic jurisprudence, the attitudes, values and beliefs of close family members, societal norms and ethics also play influential roles.

Participation

Participation is a principle of social justice, where service users are given the opportunity to participate in decisions that affect their life. Working as a social care worker with service users day to day, there are many opportunities to support participation. The promotion of meaningful participation of the people we work with is a human right and embedded in international rights law. In some situations, however, participation in social care practice can include the process of making decisions on what is deemed to be in the 'best interest' of service users. The Assisted Decision Making (Capacity) Act 2015 outlines that all necessary steps need to be taken to support a person's participation in the decisions that affect their life. A person is deemed as having capacity, unless *'he or she is unable – (a) to understand the information relevant to the decision, (b) to retain that information long enough to make a voluntary choice, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his or her decision (whether by talking, writing, using sign language, assistive technology, or any other means) or, if the implementation of the decision requires the act of a third party, to communicate by any means with that third party'* (DoH 2015: 17). It is also important to note that just because a person is deemed not to have the capacity to make one decision, it does not mean that they will not have the capacity to make further decisions. According to the 2015 Act, in all cases the person is first deemed to have capacity.

TASK 4

Reflect on past team meetings and think about the different approaches and attitudes that were voiced by fellow team members with regards to supporting service users. Think about what you read about social justice. Reflect on the outcomes of the meeting. Were they based on the service users' will and preference? Was capacity considered for every decision? Why is this discussion crucial in relation to social justice? Have a critical discussion.

Case Study 1

Ronnie is a 32-year-old man who lives in a residential community house with five other people with disabilities. He and his key worker are reviewing the yearly goals of his person-centred plan. Ronnie had in his plan that he wanted to give his room a makeover, and his key worker went out of her way to collect catalogues and measure his room to make sure everything fits. However, Ronnie decided that he would like a red wall with lots of Manchester United posters and he wants to keep everything else the way it is. The key worker is trying to persuade Ronnie to take the opportunity to get all the walls painted and bring in new furniture. Paul is adamant that he only wants the red wall with the posters.

Discuss this case and give a rationale for your opinion.

Social care workers need to be aware of rights, in order to support individuals to participate fully, based on their will and preference, in society. It is a balance between supporting people to live to their full potential, while being respectful to a person's will and preference. This can be challenging, as sometimes service users do not want to make the decision to act in the way that we deem is in their best interest.

Participation in Practice: Politics and Sexual Relationships

Political participation gives people a chance to develop networks with other people who might experience similar challenges in society. It is the basis of any movement. It empowers disadvantaged groups and creates opportunities to combine skills and talents. Social care workers play an important role here. Often the service user needs the confidence, information, encouragement and an easing of the way to get there. Role modelling, adjusting the environment, travel training, practising speaking in public (for instance at house meetings), are some examples of how social care workers put supports in place for service users to acquire social justice.

Political participation of people with an intellectual disability appears still a challenge to achieve, although this topic has been discussed more in recent years. Political participation is slowly getting more attention within the disability landscape, but there are still many intellectually disabled people, particularly in congregated settings, who are deprived of exercising their right to vote. This demonstrates that social justice is not achieved and we as social care workers can have a significant role to play to change this. Making sure service users are registered to vote is the first step. More and more organisations have good resources to help service users to make an informed choice, for example practising, using made-up ballot papers, how to fill out voting slips correctly; making sure service users do not accidentally spoil their vote. Voting is in many countries interlinked with the condition of legal capacity which recognises people making their own decisions. For example, in Germany, people with intellectual disabilities are not allowed to vote, despite that country's

ratification of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). Therefore Germany is not compliant with Articles 12 or 29 of the UNCRPD. The right to political participation is enshrined in the Convention's Article 29, 'Participation in political and public life'.

Participating in a full life includes equal enjoyment of sexual relationships between intellectually disabled people in congregated settings. This is a subject which has been seen as 'the pink elephant in the room', evident from the lack of policy and legislation to support people with disabilities. In my practice I have experienced organisations trying to address this issue by developing policies which acknowledge the equal rights, sexual needs and desires of people with an intellectual disability. While people are still living in congregated settings in Ireland, opportunities for privacy can be challenging. When we look at jurisprudence in Ireland one needs to point out the Criminal Law (Sexual Offences) Act (DoJ 2017), with its disability-specific offence approach. Section 21 describes the different situations deemed unlawful when a person has sexual intercourse with a 'protected person' or someone who lacks the capacity to give consent to the sexual act. People are deemed to lack capacity if *'by reason of a mental or intellectual disability or a mental illness, incapable of (a) understanding the nature, or the reasonably foreseeable consequences, of that act, (b) evaluating relevant information for the purposes of deciding whether or not to engage in that act, or (c) communicating his or her consent to that act by speech, sign language or otherwise'* (DOJ 2017: 17-18). It is important for social care workers to be aware of the legislation and to remember the Assisted Decision Making Capacity Act (DoH 2015) which means that all persons are deemed to have capacity first.

Please discuss following case example in class:

Case Study 2

Anna is 46 and is going out with Patrick (32). Anna and Patrick both use a day service and they have known each other for a long time. The day service used to be a workshop, but it is not any more. Anna and Patrick enjoy holding hands and kissing. They both tell each other that they would like to have sex. Anna lives with her sister and Patrick with his parents. Patrick is not allowed to visit Anna. Anna has been invited to Patrick's house for dinner twice. But Anna does not go to visit him any more, because her sister does not want Anna to be with Patrick. Anna and Patrick say that they are engaged. Once Anna was out with her key worker and stopped at a jewellery shop because she wanted to have a look at the engagement rings. The jeweller said that she must grow up for that and smiled at the care worker, who answered, 'She is forty-six'. Anna left but did not really understand why the jeweller said she would have to grow up. Anna and Patrick have been together for the last ten years.

TASK 5

Discuss this case study, keeping in mind the four principles of social justice and the relevant legislations. If you were Anna's key worker, what would you do to support her to live a full life?

www.mencap.org.uk
www.inclusionireland.ie
www.nda.ie
www.hiqa.ie
www.internationaldisabilityalliance.org/

Knowledge about one's rights, for example an understanding of the UNCRPD, and making this information accessible is vital. There are many organisations (Inclusion Ireland, NDA, Mencap, IDA) who have accessible resources for service users and social care workers to tap into. These documents are available as 'easy read materials' and can advise service users, for example, on how, where and to whom to complain if there are violations of any rights. It is worth mentioning that social care workers need to support service users to become self-advocates, so they can step back and give people the chance to develop and use their own voice.

Role of the Social Care Worker

The social care worker plays a vital role in the lives of many marginalised groups. In other words, they become an 'advocate' for social justice. The aim is to try to support people to access and participate in a fair and equal way in the day-to-day life in 'mainstream' society, just as others can. Social justice underpins a social care worker's practice on many levels. For example: to have access to health care, to be able to make informed decisions, to discover choices and alternatives, and to try new things out or to support change. The social care worker can also support relationships service users have with partners, families and friends, can enhance a person's access to education or recreational activities, support people to look after their finances, and be aware of and provide opportunities to integrate cultural diversity within the setting. Social care workers also facilitate the exercise of rights, for example by supporting people to get the right information, to speak up for themselves and to participate in the political landscape, depending on the individual's wishes. We need to continue to engage with service users to ensure their voice is included in all matters related to social justice.

Tips for Practice Educators

Possible tasks to complete on placement under the guidance and direction of the placement supervisor:

- With service users, visit the local Citizens Advice Bureau, meet the person who is responsible for advising people with disabilities, get a contact number, say hello.
- Network with NGOs – find out what organisations are in your community and organise a visit.
- Encourage service users to become involved in local advocacy groups or community organisations.
- Promote opportunities for service users to meet peers from other services, advocacy groups, for example.

Student social care workers will find it very beneficial to keep up to date with what is going on within the organisation, external organisations, self-advocacy groups, NGOs, government initiatives and university projects. What is on offer? Where could the service users piggyback on existing projects?

Introduce the student to social stories, timetables, travel plans, picture keyrings, memory markers, visual diaries, which are a great support to many.

Look at extra training, e.g., computer skills, phone skills, internet safety, upskilling, QQI courses, appearance, speaking in public, how do I present myself, how do I want to present myself, makeovers, learning how to hold and participate in a meeting, note taking, what information to keep, how to get to decision makers, knowing my TDs, knowing how the government works.

Assist the student in supporting service users to use technology, explore different apps which can help people to write a letter or to take notes, or learn how to use social media and about the dangers involved in using the internet.

Find out what courses are offered in the local colleges. Are they interesting, suitable, inclusive, accessible?

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Chapter 64 – Laura Doyle

Domain 5 Standard of Proficiency 2

Understand and apply a human rights-based approach (HRBA) to one's work including the promotion of the service user's participation in their own care; ensure clear accountability; apply principles of non-discrimination; support other staff members to empower service users to realise their rights; be aware of the legality of actions within a service including the need to comply with any relevant legislative requirements including adhering to human rights obligations

KEY TERMS

Human rights-based approach

FREDA principles

Participation

Non-discrimination

Social care is … supporting people to realise and work towards their desirable future by establishing strong interpersonal relationships and using a human rights-based approach.

Introduction

In Chapter 3 I introduced the concept of the human rights-based approach (HRBA) in social care in the context of examining of how social care workers act in the best interests of service users with due regard to their will and preference. This chapter examines how practitioners can apply a rights-based approach in their own practice, while upholding the principles of non-discrimination across all aspects of their work. We will also look at how social care workers can increase and promote participation of service users and also examine the topic of accountability. Opportunity will be provided throughout for the reader to reflect on how they can support this proficiency in practice.

Human Rights

Human rights, as stated in the Universal Declaration of Human Rights (1948), are the universally agreed basic rights and freedoms that should be available to all people simply based on their humanity. We are all born with human rights regardless of nationality, gender, religion or any other status. According to Harris and White (2018), human rights are absolute, qualified or limited.

- **Absolute rights** cannot be restricted in any circumstance; they include rights such as the right to life or the right to be free from torture.
- **Qualified rights** can be infringed upon provided there is justification, e.g., the right to freedom of expression, the right to privacy.
- **Limited rights** can be restricted, or limited, by specific circumstances such as the right to liberty, which can be restricted when a crime has been committed and a person is imprisoned. (Harris & White 2018; Council of Europe 1950).

There are various international and national human rights instruments. The table lists some of the main human rights instruments that relate to social care:

International Human Rights Instruments	Irish Specific Legal Framework
Universal Declaration of Human Rights 1948 (not a legally binding instrument but a declaration of agreed-upon values and standards)	Bunreacht na hÉireann (Irish Constitution) 1937
European Convention on Human Rights 1950	Employment Equality Acts 1998-2015
International Convention on the Elimination of All Forms of Racial Discrimination 1965	Equal Status Acts 2000-2015
International Covenant on Civil and Political Rights 1966	Mental Health Act 2001
International Covenant on Economic, Social and Cultural Rights 1966	European Convention on Human Rights Act 2003
Convention on the Elimination of All Forms of Discrimination Against Women 1979	Disability Act 2005
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment 1984	Health and Social Care Professionals Act 2005
Convention on the Rights of the Child 1989	Citizens Information Act 2007
International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families 1990	Health Act 2007; and Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.
International Convention for the Protection of All Persons from Enforced Disappearance 1990	Irish Human Rights and Equality Commission Act 2014
UN Principles for Older Persons 1991 (not a legally binding instrument, but agreed-upon principles which should be incorporated by local governments in frameworks and programmes)	Assisted Decision-Making (Capacity) Act 2015
Convention on the Rights of Persons with Disabilities 2006	
Charter of the Fundamental Rights of the European Union 2012	

Human Rights-Based Approach

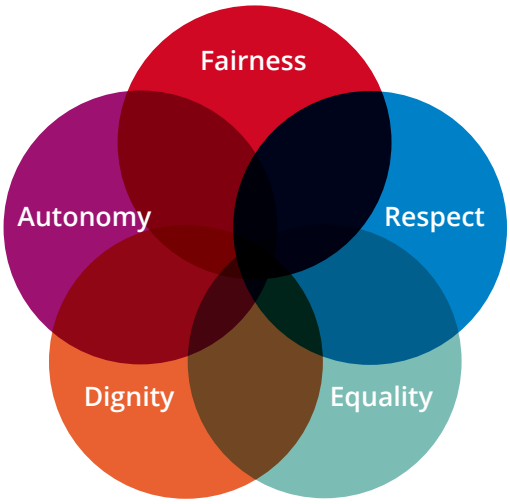
Garcia Iriarte (2016) describes a human rights-based approach, in the context of examining different disability models, as the way that society provides for equal opportunities for all members to realise their rights regardless of difference. Difference in this context is seen as an inherent part of the human condition. Dukelow and Considine (2017) view a rights-based approach as an approach 'which advocates a guaranteed level of social provision as a matter of right and entitlement' (Dukelow & Considine 2017: 323).

Curtice and Exworthy (2010) define a human rights-based approach to care as a 'bottom-up' approach whereby the clinical processes, organisational practices and culture of a service support and protect the human rights of people who use social care services.

HIQA (2019a) describes a human rights-based approach as an approach that promotes, supports and protects the inherent rights of people using social care services and supports, and guarantees support as a matter of right.

The FREDA Principles

Figure 1: The FREDA principles, HIQA (2019a) included with permission.



According to Curtice and Exworthy (2010) a human rights-based approach can be supported by adhering to the core principles of fairness, respect, equality, dignity and autonomy, or the easy to remember acronym FREDA. HIQA introduced the FREDA principles to Irish health and social care services in 2019 in its document *Guidance on a Human Rights-Based Approach to Care and Support in Health and Social Care Services.* The FREDA principles were first introduced by Curtice and Exworthy (2010) and have already been used in the English health and social care services (HIQA 2019b). A breakdown of each principle is outlined below.

Fairness	The principle of fairness means that due consideration is given to the person's will and preference in relation to a decision to be made about their care or support. The person is at the centre of the decision-making process; their opinions and views are sought and weighed against any other important factors in relation to the decision being made.
Respect	Respect applies not only to the person but also to their value system. This principle upholds the objective, unbiased consideration and regard for the rights, values, beliefs and property of other people.
Equality	The principle of equality warrants that people are not treated differently or less favourably than other people based on any of the grounds of discrimination as set out in law. Equality also ensures that people are afforded equality of opportunity.
Dignity	The principle of dignity ensures that each person is treated as a human being, that they are treated with compassion, care, and in a way that supports their self-respect.
Autonomy	Autonomy is the principle of self-determination whereby a person makes decisions on how they live according to their own values, beliefs and preferences. It involves a person using a service being informed about all aspects of their care and support.

Source: Curtice and Exworthy (2010); HIQA (2019a)

(HIQA (2019a) reprinted with permission.

The PANEL Principles

PANEL is another human rights-based approach, adopted by the Scottish Human Rights Commission in their National Action Plan for Human Rights. PANEL focuses on understanding the core underlying values and core principles of human rights instruments which, in this approach, are participation, accountability, non-discrimination, empowerment and legality (Scottish Human Rights Commission, cited in Smith 2018):

Participation	The principle of participation means that the person should participate in all aspects of decision-making that affect them.
Accountability	Accountability requires that human rights standards in services are monitored to ensure clear accountability.
Non-discrimination	All forms of discrimination on any of the protected grounds enshrined in law are prohibited.
Empowerment	Empowerment, as a human rights principle means that people are supported to realise and exercise their human rights.
Legality	The principle of legality ensures that practices and supports are grounded in human rights instruments and laws.

Source: Scottish Government 2015

On further examination of the proficiency it becomes clear that this proficiency itself has been designed and based on the PANEL principles:

- The promotion of the service users' **participation** in their own care
- Ensure clear **accountability**
- Apply principles of **non-discrimination**
- Support other staff members to **empower** service users to realise their rights
- Be aware of the **legality** of actions within a service.

Supporting a Human Rights-Based Approach using the FREDA or PANEL Principles

A human rights-based approach in social care is the integration of principles and standards of international human rights instruments into social care policy and practice. A human rights-based approach empowers people to know and claim their rights (Smith 2018). When we discuss human rights in social care, many rights come into focus, including:

- The rights of the child
- The rights of people with disabilities
- The rights of older people
- The rights of women
- The rights of people with mental health conditions
- The rights of members of socially marginalised groups
- The rights of the social care worker.

Understanding and having extensive knowledge of all the different human rights instruments can be a daunting task; however, Curtice and Exworthy (2010) argue that understanding and implementing the FREDA principles negates the need for technical knowledge of various rights instruments as the FREDA principles capture the underlying concepts and principles which underpin human rights instruments. As social care workers, we have a duty to uphold the rights of people we support so we should be aware of and have knowledge of the different human rights instruments that apply to our role. The FREDA or PANEL principles will help the practitioner promote and adopt a human rights-based approach in their work without the need to spend an excessive amount of time on the legalistic interpretation and implementation of rights, instead focusing on the underlying values and principles. Implementing a human rights-based approach in social care can be achieved by following these principles and embedding them as part of our everyday practice and in our interactions with service users.

Case Study 1

A Human Rights-Based Approach in Practice

Margaret is a woman in her forties who lives at home with her elderly mother. Margaret has an intellectual disability and attends a day service centre where she receives support from her social care worker, Jane. On arriving at the centre on Monday, Margaret informs Jane that she won't be attending the centre on Wednesday as she has a doctor's appointment. Jane asks Margaret if she would like to let her know why she is attending the doctor. Margaret says that her mam wants her to have a smear test. Margaret informs Jane that she doesn't know what a smear test is or what it is for. Jane sits down with Margaret to explain what a smear test is and what it is used for. Margaret is initially shocked by this information and states that she does not want to have it done but is worried that if she doesn't she will upset her mam. Jane explains to Margaret that she does not have to have the smear test if she does not want to.

Worried that Margaret's views are not being sought or supported, Jane seeks further guidance from her line manager. Her line manager asks Jane to seek consent from Margaret to contact Margaret's mam for more information and to arrange a meeting to put a plan together on how Margaret will be supported using a human rights-based approach. After getting consent from Margaret, Jane contacts her mother, who informs Jane that there is a history of cervical cancer in Margaret's family and that she booked her an appointment because she believes that early detection is key, as Margaret is at risk.

A summary of the key steps taken that followed a human rights-based approach:

1. Margaret was informed at all stages of the decision-making process and her will and preference and her consent was continuously sought.
2. With Margaret's consent Jane arranged to have a meeting with Margaret, herself and Margaret's mother to discuss Margaret's will and preference.
3. Margaret was supported to communicate to her mother her decision not to attend the doctor's appointment for the smear test.
4. Margaret's mam felt that because Margaret has an intellectual disability she is not able to make decisions for herself and should just go ahead with the smear test.
6. Jane spent time explaining to Margaret's mam that although Margaret has an intellectual disability, she has the same right to make decisions on her own healthcare as anyone else.
7. During the meeting, Margaret stated that she doesn't know much about cervical cancer and the smear test but would like to find out more and that maybe the test is something she could do in the future.
8. Jane asked Margaret if she would like to put a plan in place to find out more about cervical cancer and the smear test in a way that she can understand. She agreed to this.
9. Jane developed a plan for Margaret to be informed about cervical cancer and the smear test using accessible language that Margaret will understand, and given over a period of time that is conducive to Margaret's decision-making.
10. Jane regularly sought guidance and support from her line manager to ensure accountability and also to ensure that she was upholding a human rights-based approach in line with her own obligations and duties as a social care worker. Jane documented all stages of her work that supported Margaret's human rights in line with her organisation's report-writing policy and procedures.
11. Jane and Margaret regularly work together on her plan to find out more information on cervical cancer and the smear test so that Margaret can make an informed decision on her healthcare.

Promoting Participation

One of the key ways in which social care workers can embed a human rights-based approach in their practice is by ensuring that service users are involved and participate in all aspects of their care. Participation involves service users playing a fundamental role in influencing and shaping the services they use. According to Warren (2007) participation in social care can take place in many different forms, including:

- Individual care planning and reviews
- Service planning and development
- Staff recruitment and training
- Research.

In disability services in Ireland there is a fundamental philosophy that there is 'nothing about me without me', meaning that people need to be involved in all decisions and aspects of their care and support; their opinions and views need to be actively sought at all stages of any decision-making processes. For example, at an everyday practice level it could mean the involvement of the service user in choosing who they receive support from, or at a governance level by the service user being involved in the development of organisational policies and procedures. Decisions on services and supports for people should never occur without the involvement of the person, or persons, to whom decisions relate. Decisions on the care and support of a service user should only occur with participation and involvement of the service user at the centre of this process. This can occur and be supported by the social care worker individualising the decision-making process, for example designing any decision-making interventions around the person's attention span and the amount of time they can focus on a particular issue, so that it is conducive to the person's decision-making capacity. Some of the ways in which practitioners can support this is by having service users choose where meetings take place, for how long, and who will attend.

TASK 1

Place yourself in the position of a service user who is being supported by a social care worker. How would you like to be supported to participate in your own care?

Social care workers will need to utilise their problem solving and negotiating skills where there are instances of resistance or conflict with the service user; it is in these moments that the relationship between the practitioner and service user is of utmost importance. As social care workers we need to continuously look for and identify opportunities to promote participation for service users in all aspects of their care. The illustration below, based on elements identified by Beresford (cited in Harris & White 2018), highlights some more ways in which social care workers can increase service user participation.

Figure 2: *Key elements to increase participation*, Beresford, cited in Harris and White (2018)

Accountability in Social Care

Social care workers have several lines of accountability: to act within the law; to act according to codes of conduct as set out by regulatory bodies; organisational accountability to line managers and organisational policies and procedures; and accountability to service users. Social care workers are expected to adhere to these various lines of accountability.

Simply put, accountability means being answerable to questions relating to personal standards of professional practice. For social care workers, professional accountability ensures that we operate and adhere to practices and standards as set out by law in relation to our practice. To help ensure accountability, it is important that social care workers are aware of the various lines of accountability in relation to their practice and also various legal frameworks that underpin our practice, some of which are outlined in Figure 1 above. The code of conduct for social care workers is legally outlined in the Social Care Workers Registration Board Code of Professional Conduct and Ethics Bye-Law 2019, which sets out the standards of ethics, conduct and performance expected of registered social care workers. To ensure accountability it is important that social care workers adhere to this code of professional conduct and ethics.

Principles of Non-discrimination

Discrimination means that one person is treated less favourably than another person in a comparable situation. The Equal Status Acts 2000-2018 prohibit discrimination in relation to access to and use of goods, services, accommodation and education, and set out nine grounds of discrimination: gender, civil status, family status, sexual orientation, disability, age, race, religion and membership of the Traveller community.

There are two types of discrimination; direct and indirect. Direct discrimination is when a person is treated less favourably than another based on any of the protected grounds. Indirect discrimination occurs when practices, laws or procedures place a person who differs under any of the protected grounds at an unfair disadvantage as compared to another person (IHREC 2020).

According to the UN Committee on Economic, Social and Cultural Rights (2009) the principle of non-discrimination seeks to ensure that rights are exercised without discrimination. Within social care the principle of non-discrimination could be interpreted as the provision of care and supports to service user without discrimination based on any of the protected grounds. As social care workers it is important that we uphold and follow principles of non-discrimination in all aspects of our work. Upholding principles of non-discrimination in practice involves supporting other colleagues and staff to promote the rights of service users.

Conclusion

This proficiency can at first appear a challenging proficiency to grasp. However, as shown in this chapter, by breaking down the proficiency we can begin to see how the different aspects of a human rights-based approach, non-discrimination, participation and accountability all interlink and are at times interdependent on one another. As social care workers it is imperative that we follow these principles throughout the course of our work and that we are constantly making ourselves aware of various legal and regulatory frameworks relating to our work. Embedding the FREDA or PANEL principles into our everyday practice can offset the need for a thorough legalistic knowledge of all these different frameworks. This does not negate the need for social care workers to have knowledge of these legal and regulatory frameworks but rather supports their practical implementation in social care practice.

Tips for Practice Educators

As discussed, this proficiency can at first seem a complex proficiency for students to grasp simply because it can appear to have many different aspects to it. Breaking down the proficiency, as outlined in this chapter, can help the social care student get a grasp of the proficiency's fundamental principles and begin to see how they correlate, relate and interlink with one another. The student can then start to reflect on how they might support this proficiency in practice and what potential obstacles or barriers might be faced by social care workers in practice. It is important that students are supported to reflect on societal views of various marginalised groups and how barriers exist that place these groups at a disadvantage. This proficiency could be linked directly to subjects in the social sciences, including law, public policy and sociology. There is ample opportunity for the student to begin to interlink many theories in these subjects to support their theory-to-practice skill set.

To support the learning for this proficiency, it is fundamental that students to reflect on how they could implement a human rights-based approach in their practice and what different skills could support this. The *Guidance on a Human Rights-based Approach in Health and Social Care Services* (HIQA 2019) provides many case studies on a human rights-based approach which can be used by practice educators in their teaching with students to help facilitate discussion and refection on how this approach is supported in practice and on instances where this approach is not supported in practice. The practice educator could utilise reports or documentaries of real-life instances as discussion and reflective pieces.

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Chapter 65 – Antonia Kenny

Domain 5 Standard of Proficiency 4

Demonstrate a critical understanding of relevant biological sciences, human development, social and behavioural sciences and other related sciences, together with a knowledge of health and wellbeing, disease, disorder and dysfunction relevant to the role of a social care worker.

KEY TERMS

Social care work

Health and wellbeing – a holistic approach

Relevant and related sciences

Human development

Social care is … working with people in a holistic manner, most importantly recognising the person not just as a label but first and foremost as human, as a whole person.

Social Care Work

In practice a social care worker 'uses shared life-space opportunities to meet the physical, social and emotional needs of clients' (Social Care Ireland 2020). When we leave college, we are equipped with a 'toolbox' of skills and knowledge that we can apply in practice. Practice can vary across the lifespan of service users, in different care settings, and when working with individuals, no one size fits all. This is where, in theory, we dip into our toolbox. However, in practice the reality can be quite different – social care workers can wear many hats, encounter many challenges, along with plenty of opportunities!

Relevant and Related Sciences in Social Care

The complexities of social care bring with them the requirement for a knowledge base that is vast and varied. In order to practise with a holistic and interconnected approach, it is important for a social care worker to have an understanding of what is meant by the sciences related to social care practice. Science can be defined as 'a systemically organised body of knowledge on a particular subject' (Oxford Languages, online) and some of the key sciences used in social care are biological, human development, social and behavioural sciences. Other related sciences include social policy, nutrition and politics. While the biological sciences study areas such as life and organisms, human development looks at improving wellbeing across the lifespan. Social and behavioural sciences relate to the study of society and individual relationships to it.

In relation to health there are a variety of key theories and approaches to wellbeing. With this in mind, the biopsychosocial model, coined by George L. Engel in 1977, is an approach which interconnects the sciences in a way that can be used in our practice.

TASK 1

Watch the video on chronic pain and the biopsychosocial approach: https://youtu.be/B14_2TS7RHM

Determinants of a person's health can also be explored using a framework developed by Dahlgren and Whitehead in 1991. This framework maps the relationship between an individual, their environment and their health.

TASK 2

Watch the video on the social determinants of health
https://www.youtube.com/watch?v=8PH4JYfF4Ns

Furthermore, the Ecological Systems Theory, developed by Bronfenbrenner in 1979, is yet another framework which a social care worker can examine individuals' relationships with wider society.

TASK 3

Watch the video on Bronfenbrenner's Ecological Systems Theory
https://www.youtube.com/watch?v=HV4E05BnoI8

Health and Wellbeing – A Holistic Approach

The constitution of the World Health Organisation (WHO) defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO 1946). In order for a service user to achieve fulfilment in these areas, it is important that we as social care workers view health and wellbeing as being interconnected. This means looking at the whole person, not just from the perspective of labels or through one particular scientific or developmental lens. Each area of human health and wellbeing is linked, overlapping with the others in a variety of ways.

Although labels or a diagnosis can be beneficial when accessing correct support services or understanding behaviour and needs, it is also important for a social care worker to keep an open mind, which can have a beneficial impact on the care a person receives in various areas of their lives. For example, a service user declining to get out of bed in the morning may be interpreted as 'displaying behaviours that challenge'. This 'behaviour' may be communicating to staff, e.g., 'I'm not happy' – the reality might be that the person is having mental health issues, possibly due to lack of contact with a family member. Behaviour is communication, and it is important to understand that a particular behaviour may indicate emotional, physical or social ill-health.

Using a holistic and interconnected approach ensures that all the needs of the person at the centre of our care are considered in our practice. It is worth noting that supporting a person with their health and wellbeing means not only applying a person-centred approach but also working in partnership with other stakeholders, including family members, carers and disciplines other than social care.

TASK 4

Take a moment to think what your own current health and wellbeing requirements are. Now make a list under these headings – Physical, Mental and Social. Next think of actions you can take to meet these needs.

Case Study 1

Susan (pseudonym) is a 26-year-old woman who moved five months ago to live in Meadow Lodge, a residential service for people with autism on the outskirts of a large town. Susan lives with two others; however, they have very little in common apart from their age group. Susan enjoys spending time with family, watching television and walking independently to the local park.

During her time in Meadow Lodge, Susan's mood has changed from being smiley and relaxed to withdrawn or agitated. Some days Susan declines to leave her bed and often chooses not to eat. As Susan is non-verbal, she at times communicates her mood by acting out towards staff physically – biting, pinching and hitting out. On other days Susan engages positively in daily activities and shows her mood in positive ways such as smiling.

Taking into consideration Susan's health and wellbeing needs or wants under the headings Physical, Mental and Social, what could be causing Susan's changes in behaviour and mood? The templates below can be used as a guide.

TASK 5

Step 1: Identify each need or want for Susan's care plan under the following headings:

Mental Health & Wellbeing	Physical Health & Wellbeing	Social Health & Wellbeing
1.	4.	7.
2.	5.	8.
3.	6.	9.

Step 2: Make a plan for each.

	Need/want	Action to be taken	Responsibility of whom	By when
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

Step 3: Identify the priority areas.

Decision-making Skills

A social care worker's ability to demonstrate in their practice a critical understanding of the relevant and related sciences, human development and health and wellbeing prevents the risk of them making subjective rather than objective decisions. Anyone can learn the theory from books, but the ability to apply it meaningfully is a skill in itself. As the social care worker matures in their role, so will their understanding and ability to apply theory to their practice. Decision-making occurs on many levels and with many factors that will have an influence or impact a service user at that time or in the future.

Awareness of one's own values, beliefs and attitudes when making decisions, alongside the service user, based on their needs or wants, is also important. As an example, one social care worker might believe that bread or cheese is unhealthy; another believes that they are not. These ideals will impact how the social care worker supports the service user, unless they possess the ability to take a reflective step back and ensure that the service user is at the centre of the plan. Possessing an understanding, knowledge and awareness of the sciences and health and wellbeing leads to objectivity, allowing for support given to be based on the service user's needs and wants rather than our own opinions.

Tools

A structure around making these considerations can be created in the form of care plans. As they are live documents and should be reviewed regularly, they change over time alongside the development of the service user during their life span. Recent times have seen changes in the way care plans are documented. Technology has been developed, such as *Aspiricos iplanit*.

Aspirico's iplanit, which provides a web-based system that captures information digitally around service user care plans (which can be based on the twelve pillars of the New Directions policy). A user of iplanit can choose to share their password with the people they care about. This means that they can give access to the information uploaded and stakeholders can provide support while keeping the person at the centre of it all. For instance, a sibling living in Australia can give support. Features include pictures, videos and audio clips that can be uploaded, and there is a personal calendar. Care plans are available in an accessible format that is easy to use. As the software essentially belongs to the user, their iplanit journey is ongoing, even if they move between services (Aspirico website).

Tips for Practice Educators

Practice placements provide an opportunity for a student to demonstrate and develop their understanding of the knowledge they have acquired in their education setting. In order to achieve the requirements of this proficiency, it is important that the student is afforded the chance to meaningfully apply the theory around the relevant sciences, human development and health and wellbeing in practice.

The practice educator can kick-start the process even before the student starts their placement. As any overarching legislation is streamlined, it leads to each social care setting having different policy and ethos. Social care is diverse not only in settings but also in staffing roles, leading to many titles and responsibilities. To ensure that the student is well prepared for this, the practice educator can provide the student with a pack before they begin their placement, including specific details of their role in the capacity of a student.

The requirements for the student to achieve this proficiency is that they can critically apply the theory to their practice, becoming competent and confident in their assessment and decision-making skills to meet service users' wants and needs regarding their health and wellbeing. To accomplish this a student can be asked to research the relevant sciences and theory around health and wellbeing (including health promotion) before starting their placement. A placement educator can suggest theorists such as Bronfennbrenner, Erikson, Engel or Dahlgren and Whitehead, which will may help structure the thoughts of the student and encourage them to look at the bigger picture for the service user.

A placement should provide a student with a safe place to explore and learn. Mistakes will, no doubt, be made and hopefully learned from, providing valuable knowledge to build on as the student matures in their professional life. Within this competency of critically understanding the related and relevant sciences, human development and health and wellbeing, a practice educator can also challenge the student in their understanding and what values and beliefs they carry regarding these areas by allowing space for reflective practice and giving supervision. A practice educator can also provide the tools to guide the student to facilitate theory in its application, such as in care planning documents.

Top Tips

- Prepare the student before their placement commences.
- Ask the student to define their understanding of the sciences, human development and health and wellbeing.
- Challenge the student's values and beliefs in a supportive manner.
- Use a systematic approach (needs assessment, planning, implementation and evaluation) to set care planning goals.
- Provide opportunities to use care planning tools with guidance from service users and experienced staff.
- Ensure use of a holistic approach when applying theory to practice.
- Address any challenges during supervision.

Suggested list of decision-making questions

Have you gathered information from all sources (service user, stakeholders, multidisciplinary, history)?	Are there any gaps in your knowledge?
Have you identified any forgotten needs/wants of the service user?	Have you eliminated other assumptions before finalising your decision – objective or subjective stance?
What are the implications of this decision?	Is this realistic?
What are the priority areas?	What else can be done?

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Chapter 66 – Helena Doody

Domain 5 Standard of Proficiency 5

Know and understand the principles and applications of scientific enquiry, including the evaluation of intervention efficacy, the research process and evidence informed practice.

KEY TERMS

Research process

Evidence-informed practice (EIP)

Principles and applications of scientific enquiry

Evaluation of intervention efficacy

Social care is … an ever-evolving integrated systems approach to working with individuals to help them lead a fulfilling and meaningful life. It places the person at the centre of the process and encompasses social justice and human rights principles.

TASK 1

Describe something that you researched for yourself – it could be a holiday destination, a college course or a college/university where you wanted to study. How did you carry out your research? Why did you choose the final destination, college, university or course? What influenced your decision? Where did you look for information? What type of information did you look for and what did you find most useful in helping you to make a decision?

Research Process

Humans are naturally inquisitive; we are always trying to make sense of the world we live in. We do this by asking questions, seeking out new information and learning from our own experiences. We navigate life by experience, observation and the example of others, whether they are family, friends, or people we perceive as having authority through acquired knowledge and/or lived experience. The search for knowledge and truth is discovered by research. We all carry out research in some shape or form in our everyday lives and, while this may not be formally conducted, we are nonetheless continually seeking information on how best to achieve our goals and often enquiring how to get the best value for money. The value in conducting research prior to investing our time or finances is that we achieve a better outcome, greater opportunities and/or the best value possible.

The following diagram outlines some of the questions one might ask and some of the steps one might take when conducting research.

Virtual Library: The Research Process (https://www.virtuallibrary.info/research-process.html)

When engaging in any form of research or developing interventions for service users, social care workers must act in accordance with and adhere to the *Code of Professional Conduct and Ethics for Social Care Workers*:

In all circumstances where consent is required prior to engaging in any assessment, intervention, treatment or service the following process must be followed:

a. take personal responsibility for obtaining consent from the service user, or from someone with legal authority to give consent on the service user's behalf
b. ensure that, if you have to delegate to a colleague the responsibility for obtaining consent, such colleague is suitably trained and qualified to undertake this responsibility
c. ensure as far as possible that the consent provided is voluntary and not the result of inappropriate pressure from a third party
d. provide the service user with sufficient relevant information, in a way that s/he can understand, to enable the service user to decide whether or not to consent
e. allow time and space, as far as possible, for the service user to take in and understand the information before reaching a decision
f. answer any questions relating to the assessment, intervention, treatment or service from the service user honestly and as fully as s/he wishes
g. respect the right of the service user to refuse consent to an assessment, intervention, treatment or service, even if you do not agree with their decision
h. follow applicable law, regulation and guidance issued by appropriate authorities in relation to the giving of information and recording of the service user's decision
i. respect a service user's advance healthcare directive in accordance with law, regulations and national policies or guidance. In emergency circumstances where it is not possible to obtain consent from the service user, you must
j. provide treatment or other intervention where this is necessary to save life or avoid significant deterioration in the health of the service user (SCWRB 2019).

Ethics and ethical approval

Prior to engaging in research is it vital to apply for and receive ethical approval. If you are engaging in research as part of an education programme, your university or college will require that you engage with the ethical approval process. This is to ensure that the principles and practices of good research are being adhered to. The *Code of Professional Conduct and Ethics for Social Care Workers* (SCWRB 2019) outlined above must also be followed. Engaging in the ethical process and applying for approval can be a long process, but research cannot commence until approval from the relevant ethics committee has been obtained.

Miles and Huberman (1994: 290-7) refer to 11 ethical issue and dilemmas that one must consider prior to and during the research process:

1. Worthiness of the research
2. Competence boundaries
3. Free and informed consent
4. Benefits, costs, reciprocity
5. Harm and risk:
    - minimising harm (non-maleficence)
    - maximising benefit (beneficence)
6. Honesty and trust
7. Privacy, confidentiality and anonymity
8. Intervention and advocacy
9. Research integrity and quality
10. Ownership of data and conclusions
11. Use and misuse of results.

There are approximately 32 health research ethics committees (RECs) in the HSE (Health Service Executive). Some approve research taking place in the organisation to which they belong; others have a regional remit and can approve hospital and community healthcare organisation (CHO) based research. Further information is available at https://hseresearch.ie/research-ethics/.

Tusla's National Research Office is responsible for co-ordinating all research activity of Tusla (the Child and Family Agency). Further information is available at https://www.tusla.ie/research/tusla-research-office/about-the-national-research-office/.

Evidence-informed practice

Engaging in reflective practice assists social care workers in evaluating both their individual and organisational relationships and practices. This in turn informs key decision-making in social care practice provision, which ultimately impacts on service users' experience.

Evidence-informed practice (EIP) underpins, informs and shapes how the social care profession delivers effective services. Engaging in EIP is a key component in social care and helps to ensure that the mistakes and shortcomings highlighted throughout the history of social care are not repeated. EIP can assist in problem-solving and in preventing harmful procedures and interventions that negatively affected service users (Aveyard and Sharp 2009). The aim of research is to learn about a phenomenon in order to create improved outcomes and meaningful life experiences. EIP first emerged in healthcare and more recently has been adopted by social care. It is used as a research method in social care to support best practice and deliver the best possible care.

> *It Indicates an approach to decision making which is transparent, accountable and based on careful consideration of the most compelling evidence we have about the effects of particular interventions on the welfare of individuals, groups and communities (MacDonald 2001: xviii).*

As suggested by Rosen (2003), a growing evidence base emanating from the implementation of evidence-based practice can guide the development, implementation and evaluation of new programmes and practices.

EIP gathers data and information that suggest whether a particular practice or intervention is working and therefore having successful outcomes in an individual's life. Research aims to help provide the most effective services based on the best available evidence that offers service users the best possible outcomes alongside enhanced life experiences. As professional social care workers, we are accountable, therefore; we must have a clear rationale for engaging in particular practices and interventions. We must ensure that our practice is informed by reliable evidence that this is the best way of providing services and addressing the needs of the individuals we are supporting. We must be able to justify and provide a clear rationale for the practices we are engaging in.

The benefits of engaging in EIP include:

- Promotes value and addresses service user needs
- Informs the development of education of the profession and social care service delivery
- Highlights the importance of developing and using research in generating new knowledge and evidence as well as a commitment to improving services and outcomes for service users.

Person-centred planning is a good example of how engaging in EIP enhances service user participation and quality of life (Rogers 1961).

Case Study 1

Thomas is a 34-year-old man living in a residential home in a large organisation providing services to persons with a disability. Thomas has presented with behaviours that challenge, and these behaviours have resulted in him being considered not suitable for independent living. Thomas's key worker introduced person-centred planning and worked with Thomas to identify and achieve personal gaols and aspirations. During this process Thomas was provided with strategies to communicate his needs and wants and to self-regulate. This resulted in a reduction in the frequency of the behaviours. As Thomas gained more control and independence the behaviours dramatically reduced. A direct correlation was made with the behaviours and lack of choice of control within his daily activities and wanting a meaningful life.

Thomas was referred to speech and language therapy to develop his communication skills. He also participated in an advocacy group and developed the skills needed to advocate for himself and express his opinions on how he wants to live his life. Thomas's progression was evident in the development of his most recent person-centred plan. Thomas identified that he would like to work towards becoming more independent in his daily life. In particular, Thomas highlighted that he would like to move out of the group home and live in an apartment on his own. This goal presented some challenges, and both Thomas and his key worker faced challenges, including financial issues and accessing suitable housing. To gain more knowledge and to explore how living independently would work, Thomas and his key worker attended a workshop on self-directed living. This gave him a great insight into how independent living can work successfully for a person with an intellectual disability. Thomas has started to put plans in place to gain the skills he will need to live independently in the community. He has learned to manage his finances and is learning to use public transport. He is in the process of securing an apartment to rent in the local town, and has been working with his key worker to build up practical living skills like cooking, cleaning and budgeting, with a view to working towards his first overnight stay in the apartment on his own.

Thomas's key worker also acquired new skills as he attended a course which focused on empowering the individual and on supporting persons to live independently. He used this learning to facilitate Thomas to have more choice and control over the way he wanted to live his life, and to encourage Thomas's circle of support to identify their role in supporting him to achieve his goals. He also engaged in inter-agency collaboration to access resources to help Thomas achieve his goals.

Principles and applications of scientific enquiry

The word science is derived from the Latin phrase *de scienta*, which means 'to know'. Inquiry is the search for information and explanation. It is also referred to as the 'search for truth'. To engage in scientific inquiry is to study our world or a particular phenomenon and, based on the evidence of the research, to offer explanations. The aim of scientific enquiry in social care is to test the effect of interventions and to evaluate their success or otherwise. It is an approach to problem-solving by exploring and developing ideas that are based on scientific evidence.

There are many different ways to engage in scientific enquiry. The basic steps are listed below. It is important to note that this process can be cyclical; one may have to repeat the steps to reach a conclusion or workable solution.

Evaluation of intervention efficacy

TASK 1

Think of something you have researched and invested time and finances in. Ask yourself: Was the outcome what I expected? Would I invest time and money in it again? Would I recommend the experience/value to family or friends? Would I choose the same service/option again?

In asking these questions, you are evaluating the service you received to ascertain if you achieved the outcome intended or if there are better options/services available. Therefore, you are evaluating the effects of the chosen intervention. In social care work, we must evaluate our practices and ask the questions: Are our services and intervention working? Are our service users and stakeholders satisfied with our approach? Can we do better?

Efficacy evaluation involves assessing the effect an intervention has on a service or service user/s. Engaging in efficacy evaluation and reflective practice is a key component in social care work and helps reduce the risk of harm. We need to demonstrate how services are making a difference. Questions that services and social care workers must ask of themselves are: Why are we/Why am I doing things this way? Is there evidence to suggest this is the best approach or are there more effective ways of doing this? Is there evidence of research that has been carried out, to review the efficacy of the intervention/approach? Are we valuing people's experience?

National and international comparisons can be made on goal setting, inspection, reviewing and evaluation. There are many ways to evaluate the effectiveness of an intervention. Enquiring as to the effectiveness, impact and quality of the intervention is key in evaluating efficacy. It is vital that social care workers and services engage in reflection and evaluation of services and interventions. Evaluation provides feedback on the effectiveness of the intervention and determines if it is appropriate for the service users or intended population.

In order to receive funding and satisfy funders and policy makers, the social care profession requires evidence that services are achieving their stated aims and that their interventions are making positive changes in providing meaningful experiences and supporting service users in their day-to-day living.

We have highlighted the importance of evidence-informed practice and research which provides a platform for service users' and social care workers' voices to be heard. However, further research is required to provide a better understanding of the relationship between research and the work of social care workers, including what organisational resources are needed to realise the aim of using research to shape practice. Third-level education programmes promote research at undergraduate and postgraduate level; however, access to participants and navigating gatekeepers can be challenging. This proficiency needs to be supported by service providers. Senior management must promote CPD by allocating resources to facilitate social care workers to engage in part-time education programmes that will enhance practice and improve services.

A multi-agency inter-collaborative approach is required to create a research culture and encourage social care workers to engage in research that will unravel structures and systems and identify gaps in service provision.

Tips for Practice Educators

Engaging in research can be challenging for students. The terminology used can be off-putting. Exploring research carried out on a regular basis and breaking down the terminology can allay some of these fears and expectations. Educators can play a key role in supporting and developing a culture of research by encouraging students to:

- Engage with peer-reviewed research papers for continuous assessment
- Critically evaluate research carried out historically. Identify gaps in ethical procedures and dilemmas
- Identify evidence-informed practice
- Participate in research. This will provide an opportunity to be the participant as opposed to the researcher
- Carry out small research projects while in a placement setting (if permitted).

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Chapter 67 – Noelle Reilly and Denise Lyons

Domain 5 Standard of Proficiency 6

Demonstrate skills in evidence-informed practice, including an understanding of competing theories, concepts and frameworks underpinning social care work and demonstrate an ability to apply the appropriate method in professional practice.

KEY TERMS

Evidence-informed practice

SKIP model

Skills in evidence-informed practice

Social care is … a process of working with people to support them to flourish and grow. Practice is based on the integration of relevant theories, concepts and frameworks underpinning the wisdom in evidence-informed practice.

Evidence-informed Practice

The Standards of Proficiency for Social Care Workers (SCWRB 2017) require workers eligible to register to apply an evidence-informed **approach** to practice (D3 SOP6 – Chapter 6), to **evaluate** evidence-informed practice (D5 SOP5 – Chapter 66) and finally, in this proficiency, to be able to demonstrate this knowledge as **skills**. 'Evidence-informed' is a term commonly used in social work literature as a way of reducing the practice-knowledge gap (Kelly *et al.* 2010). This definition of the term is applicable here as there is an acknowledgement within our proficiencies that social care graduates will need to know competing practice theories, enabling them to choose from a range of responses for each experience they encounter. Evidence-based practice is evidence based on research, which is when the worker develops theory based on the collection of data. Nevo and Slonim-Nevo (2011) described evidence-informed practice as a more encompassing view of 'evidence'. As well as including theory based on research, this view also accepts the value of the worker's practice stories, and their informed decision-making experiences and judgements. Thus, evidence-informed practice takes a broader view of what constitutes evidence. According to Nelson and Campbell, evidence-informed practice includes 'multiple strategies, processes and activities, which will vary depending on the purposes to be achieved, the contexts of practice, the availability of evidence, the individuals and/or organisations involved' (Nelson & Campbell 2017: 131). As CORU stresses the role of evidence, it is essential for students, workers and educators to understand what constitutes 'good' evidence and the difference between evidence-informed practice (EIP) and evidence-based practice (EBP), which is also mentioned in the standards (D3 SOP9 – Chapter 49).

Evidence-informed Practice (EIP)	Evidence-based Practice (EBP)
An approach to interventions with clients or service users that utilises research evidence in conjunction with knowledge derived from other sources (e.g., practice wisdom and service user preferences) when identifying an appropriate intervention to meet their needs.	An approach to interventions with service users that is based on scientific evidence. Practice is supported by proven rationale.

TASK 1

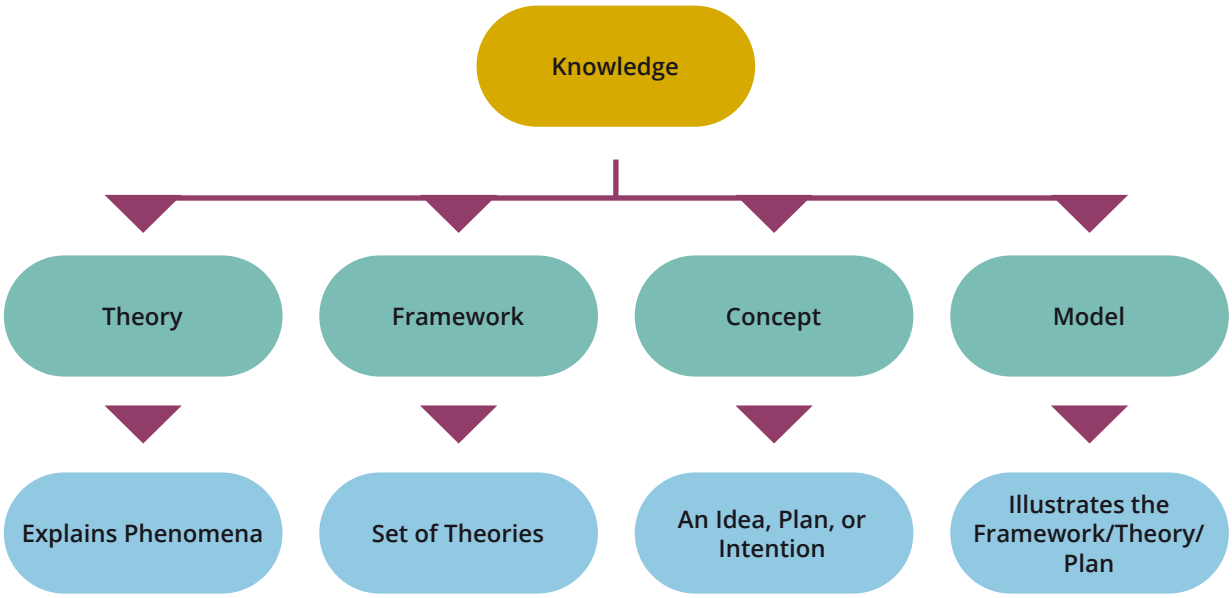
Please read Chapters 6 and 66 when you have read this chapter for a greater understanding of an evidence-informed approach and how to evaluate evidence-informed practice.

Lewis (2001) defined knowledge as evidence plus practice wisdom (knowledge obtained in practice) plus service user and carer wishes and experiences. Lewis's definition suggests that best practice in social care incorporates evidence-informed practice coupled with other salient factors. Therefore, practice is informed by evidence, but evidence is just one element (Shlonsky & Stern 2007). Holm (2010) supported this definition, but argued that organisational context, and organisational policies, procedures and guidelines must also be considered as evidence-informed practice in social care. Similarly, Brady *et al.* (2016) advocated for the development of evidence-informed practice as an approach that facilitates the practitioner to utilise research evidence in conjunction with knowledge derived from other sources when deciding on a course of action to support the service user. The common thread emerging from these studies is the need for social care workers to assess the evidence and integrate it into practice, giving due consideration to contextual influences.

Before we look at what constitutes evidence-informed practice in social care, we will briefly explain the difference between theories, concepts and frameworks and how they underpin social care practice.

Introducing Theories, Concepts, Frameworks

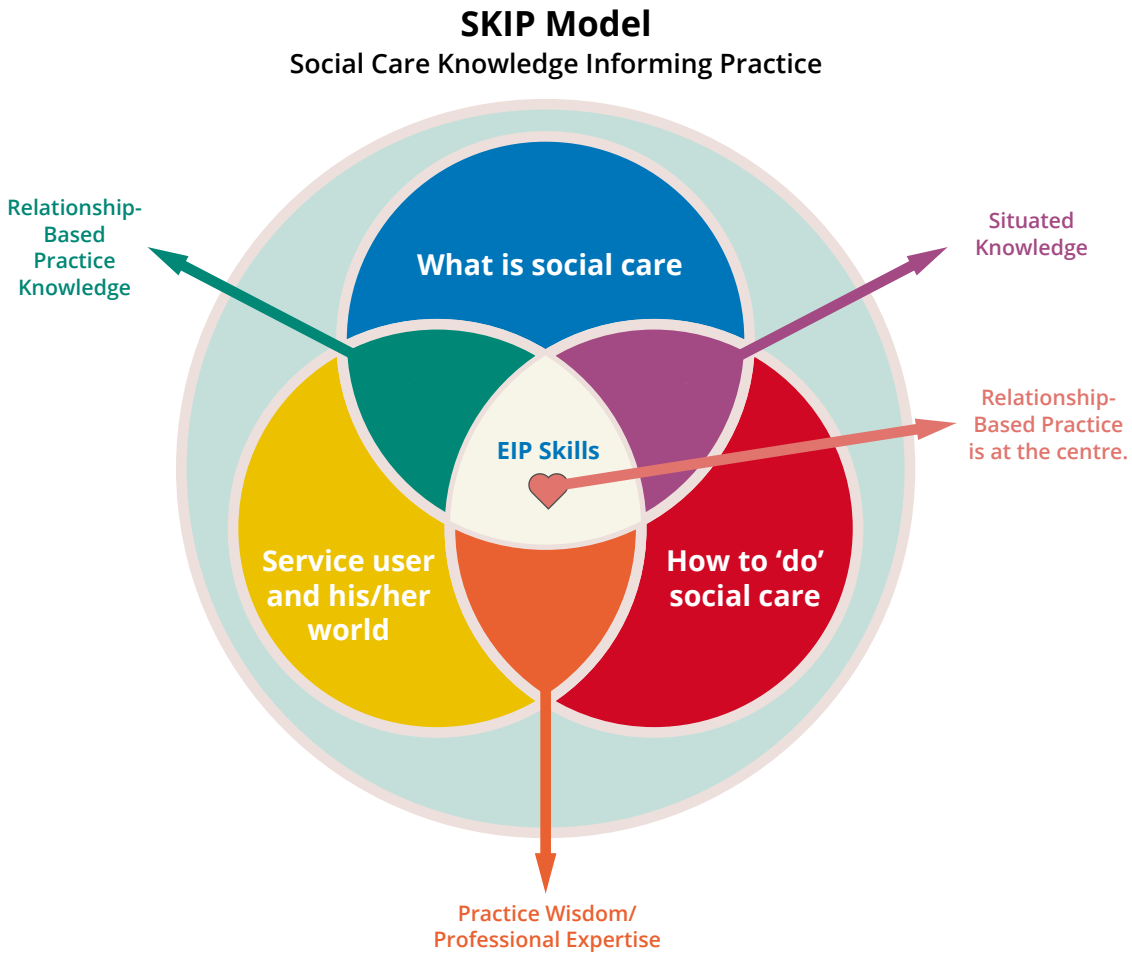
Social care practice is underpinned and shaped by various theories, concepts and frameworks. It is important that we have a critical understanding of theories that are significant in thinking about and practising social care work. In practice, social care workers critically engage with theories, reflect on their application to practice and consider their limitations. Relevant theories and concepts, when applied to social care work, have the potential to inform and improve practice. The following diagram highlights one key difference between a theory, a framework, a concept and model.



A *theory* is an idea or set of ideas that explains something (Stevenson 2010: 1829) and helps clarify a phenomenon, when we are trying to understand facts, experiences and situations. There are three categories of knowledge relevant to social care work: theories of what social care work is; theories of how to do social care work; and theories about the service user's world. A *concept* is an abstract idea (Stevenson 2010: 358), which could be a new intervention or a plan for how to solve a problem that has not been tried before with a specific service user in the setting. A *framework* is a structure which underlies a set of theories or ideas (Stevenson 2010: 685), that are widely accepted, are based on evidence-informed practice, and can become guiding principles for practice within a particular discipline. Although not included in the proficiency, a *model* is a simplified description (Stevenson 2010: 1128) of an idea or theory used to help clarify the information or used as a method of illustrating or representing the framework. The knowledge base for social care is as diverse as the profession itself. Your formal social care education adheres to a performance strategy, for example the Quality and Qualifications Ireland (QQI) Award Standards – Social Care Work (QQI 2014). Nonetheless, each programme differs in its structure and module composition. Each college/university has designed a suite of modules in each year of study to provide specialised evidence-informed knowledge and skills, underpinned by relevant theories and practice experiences. To help students understand the broad but interconnected knowledge bases for social care work, we have developed the **SKIP** Model (**S**ocial Care **K**nowledge **I**nforming **P**ractice) (Lyons & Reilly, forthcoming) to help clarify how the categories of knowledge and skills are equally valid and necessary for your holistic education.

SKIP Model – Social Care Knowledge Informing Practice

This model is evidence-informed (Lyons 2017; Reilly 2018). It aims to illustrate how all the knowledge needed to develop *professional expertise* in social care work is connected. The modules in your social care programme provide specific theories which contribute to one or more categories of knowledge. As you progress, these theories are woven together to become your integrated tapestry of skills and knowledge for professional practice. The SKIP Model (Lyons & Reilly, forthcoming) was designed to communicate the interrelatedness of evidence informing knowledge and skills, illustrating this ongoing process where you are both student (learning from new experiences) and teacher (sharing knowledge and skills gained) at the same time. This model is divided into three broad categories of knowledge, information, skills and experiences that help us understand (a) what social care is; (b) how to do social care and (c) all about the people we work with and their lived experiences, including the contexts of care in which we work and live together. How these three categories of knowledge overlap are defined as 'situated knowledge' and 'practice wisdom', with an understanding that the relationship between the service user and the worker is at the core of it all.



Knowledge Base: What is Social Care?

'Social care' is a term used to define a milieu of care-based work with 'vulnerable' or 'marginalised' people in society. In most cases, social care workers are the professionals who work on the floor, sharing daily life events with people, in either residential or day services. Social care is historically linked to institutionalised care for children in industrial and reformatory schools (O'Doherty 2003) and Church-run services for children or adults with a disability (Finnerty 2013). The profession has broadened to include new domains. such as: child and adolescent mental health; addiction; services for people who are homeless; and community/family support. The foundational knowledge for social care is provided in your formal education on your social care degree programme. Here the combination of theoretical and practice-based modules are thoughtfully designed to provide the breadth and scope required for best practice in a variety of social care settings.

We included a section in each chapter entitled *'Social care is ...'* to provide a snapshot of how each social care worker in this text defines social care work, based on their lived experience of practice. The following are some examples of what the workers deemed social care is ...

- About meeting people at a particular stage in their lives and supporting them to overcome their challenges and assist them with reaching their goals (Chapter 31 by Garreth McCarthy).
- Supporting people to live their best lives and reach their full potential through meaningful, person-centred interaction; supporting people to empower themselves through non-judgement and advocacy; encouraging and respecting the choices people make; and ensuring respect and dignity for the people we support at all times (Chapter 23 by Lynn Leggett).

- Being an extra support to a person in their time of need, being their information box, a spokesperson for them, a cheerleader behind them (Chapter 16 by Moira O'Neill).
- When I am asked what social care is, I tend to give the same answer again and again. It is about relationships (Chapter 38 by Des Mooney).
- An opportunity to harness human connection and spirit in a structured and purposeful way with the intention of improving the lives of others (Chapter 17 by Lauren Bacon).

The key themes in this random sample are supporting others to overcome challenges and live their best life; and relationship – making a purposeful connection with a person in their time of need.

TASK 2

Pick three other chapters and write down the key themes social care workers discussed in their 'Social care is' section.

Situated Knowledge

The knowledge required for social care practice is context-specific, shared and learned through mutual engagement and communication. Workers establish the knowledge base within their setting, which is negotiated, exchanged and emphasised between the members of the staff team (Wenger 1998). This is first experienced as a student on placement when you are guided by the practice educator to learn the way social care work is specifically practiced in the service. Lev Vygotsky (1896-1934) stated that all learning is influenced by the social and cultural context in which it occurs. The central premise of Vygotsky's work is that learning occurs through social interaction, mediated by physical and symbolic tools which are used to interact with the environment (Vygotsky 1978). These tools are passed from one social care worker to the next and are used to understand, engage in and ultimately change the 'physical world' of the service. In all social care settings, interactions happen through the use of tools, either psychological (language, practice stories, and relationships-based practices) or physical (universal records that everyone knows how to fill in, and the in-house policies). If social care workers move to a different setting they need to learn the policies, procedures and tools (physical and psychological) used there.

Social care services become situated learning spaces, similar to 'communities of practice' (Lave & Wenger 1991, Wenger 1998). As a learning theory, 'communities of practice' is based on the following principles: (a) all people are social beings; (b) through learning from work colleagues, workers gain competencies; (c) knowing what to do 'on the floor' is a product of 'active engagement in the world' of practice (Wenger 1998: xvi). We are not trying to define social care settings as communities of practice, but to use this framework as a way of explaining evidence-informed knowledge and how students learn the theories, concepts and frameworks underpinning social care, inside and outside the classroom. The practice educator shares the knowledge that underpins their approach to social care work, called *situated competencies* (Wenger 1998). Social care workers attribute meaning to particular stories, approaches, tools and interventions, which supports their practice. Students and new employees learn these shared practices from the staff team. Shared practices may include the role of helping and supporting others, the practice of key working, and most commonly, how the relationship is viewed as central to practice (Lyons 2017). Within the service, competing theories, concepts and frameworks help workers to understand likes and dislikes; interpret communication cues; meet needs quickly and effectively; provide support appropriately, and how to be an advocate by communicating accurate information to others.

Knowledge Base: 'How to Do Social Care'

The discussion on situated learning spaces explains why social care workers may perform different tasks depending on where they work. What social care workers 'do' is based on the service in which they work, the specific tasks, duties and policies which frame their day-to-day practice and the role they play within the multi-disciplinary team and management structure of the organisation. Due to the diverse nature of social care, with different service user groups in both day and residential contexts, the practice of care is defined and structured by the setting, which includes how the social care worker is identified and valued. This knowledge category also includes all the theories, facts and policies on how to care for others through a human rights-based approach. Importantly, understanding how to care for or do with others begins with self-awareness, pointing the reflective lens inwards to understand our values, judgements and biases and reason for entering social care (Lyons 2007, 2009).

Practice Wisdom

Practice wisdom is 'a personal and value-driven system of knowledge that emerges out of the transaction between the phenomenological experience of the client situation and the use of scientific information' (Klein & Bloom 1995: 799). This is the wisdom workers use. It is underpinned by theories, concepts and models of best practice (information) and shaped by the worker's lived experience of being with the service user. Practice wisdom is evidence, based on the combination of theoretical understanding and common sense knowledge emerging from the engagement in practice (Dybicz 2015). The knowledge acquired on how to do social care work and care for others is applied to practice. This knowledge is part of the wisdom used to guide workers in knowing how to respond to the different situations they encounter each day. Practice wisdom includes knowing how to react at a moment's notice to a sudden event or new behaviour. It is also evident in the preventive work that is done to meet ongoing needs, for example having the cup of tea ready, knowing a service user likes to sit down when they come in from the day service. Time with service users was viewed as the most important way for social care workers to develop practice wisdom as they transition from the inexperienced newcomer to the status of competent and present old-timer (Lyons 2017). The social care setting frames the practice wisdom experienced there, and this 'situated knowledge', when combined with practice wisdom, becomes professional expertise.

Professional Expertise

When defining a model for social work, Gambrill (2013) argued that practitioners can draw on their clinical expertise to integrate information regarding the individual client's personal characteristics and preferences with external research findings, thereby establishing the best intervention to address their needs. In social care practice, this is professional expertise; the worker performs best practice, underpinned by an integration of relevant evidenced-informed theory and practice wisdom, all led by their in-depth relationship and understanding of the service users' likes, dislikes and actions within the specific context of care. It is important to note that research is always evolving, and as new information becomes available, some research, ideas, concepts and practices become invalid. Consequently, all sources of evidence, from empirical research to practice wisdom, are valid and necessary to enhance the worker's expertise in how to best support service users (Rycroft-Malone *et al.* 2004). The development of evidence-informed practice skills is dependent on the sharing of knowledge and experience between workers, educators and managers involved in social care practice. This process of 'knowledge mobilisation' promotes the co-creation of evidence derived from research studies by academics and students about practice, the situated knowledge and case studies from workers and managers in different practice contexts, the practice wisdom developed from many years' experience of critical thinking and problem-solving. If social care workers are to demonstrate skills in evidence-informed practice, including an understanding of competing theories, concepts and frameworks underpinning social care work, they need to keep talking to each other, share their expertise and value equally the role of each professional in the creation of evidence-informed practice.

Knowledge Base: 'Service Users and their World'

The people we work with are described in this text as 'service users', a term currently used to describe vulnerable or marginalised adults, children or young people requiring care and support. We also work with children, young persons, residents (homeless services), trainees (day services), to name a few of the different titles used. A central component of social care education is learning about the lived experiences (disability, deprivation, abuse, addiction, homelessness, mental health, among others) of the people we work with, including how they communicate (all behaviours, sounds, language and colloquialisms). Although your social care programme will provide in-depth knowledge on the possible impact of a variety of experiences, social care is person-centred practice and the people we have the privilege to work with are experts in their own life, needs and care. This knowledge category also includes all information relevant to the development of quality service provision and how over time improvements are made to ensure the provision of safe, accountable and person-centred practice.

Relationship-based Practice Knowledge

TASK 3

1) Please read Chapter 69 for more information on 'relationship-based social care practice'.
2) Please read the case study and complete the task below to give you an exercise on how this theory can apply to social care work.

The relationship is what makes social care work distinct; it is the most important learning space in practice and this is why it is presented as the heart of evidence-informed practice in social care work. We provide care and meet needs through the relationship using our personality, our self and our relationship skills from the social care worker's toolbox (Lyons 2013). The relationship between a worker and service user is meaningful (Digney & Smart 2014) and trusting (Howard and Lyons 2014). The relationship is the 'core' of this practice (Kennefick 2006; Lyons 2009). Developing a relationship requires the personal skills of engaging, remembering details about the person, actively listening without interrupting them, and remembering the things they love and little personal things about them (McHugh & Meenan 2013). Listening in for the rhythm of each service user and tuning in to where they are in their life is also important (Maier 1992; Digney & Smart 2014). Being cognitively engaged also includes concentrating on the person and ensuring that your thoughts remain present and focused on meeting their needs (Garfat *et al.* 2018).

Case Study 1

Mary is 15 years old. She is witty, kind and mischievous. When Mary was 11, her mother passed away and Mary entered residential care. Mary had a turbulent couple of years. This is Mary's third placement and she has lived here since she was 13. She is settled and seems content. Mary has attempted to go to school but due to social anxiety has not been able to maintain her attendance. She is currently on an education programme that she attends at home and has demonstrated that she is very bright. She completes her school work daily under the guidance of a tutor, who is currently being funded privately by the residential service pending input from the Department of Education. The care team support Mary in her studies with copious supplies of tea and praise. For the most part she can study independently. Mary's father is incarcerated. Mary is very close to her older brother. They spend a lot of time together; however, he has limited means and it is not possible for Mary to live with him on a more permanent basis. Mary visits her dad once a month and they have weekly telephone contact.

Reviewing the Case Study through the Lens of the SKIP Model
Relationship-based practice knowledge: In the case study we know that Mary has the intellect to be successful in school, but that her social anxiety is preventing her from accessing an education. We know that she has tried to overcome her anxiety but has not been able to maintain her attendance in school. So the care team supporting Mary have found another way for her to attend school that does not cause her anxiety, thereby ensuring that she has an opportunity to achieve her potential. You may also note that the type of support Mary requires is emotional support, for example 'tea and praise'. She needs the reassurance that she can complete the tasks asked of her, and the comfort that small gestures such as bringing her a cup of tea brings. These gestures tell Mary that she is important, that she matters, that her needs are to the forefront of decisions made and that people around her care about her. Mary will feel validated, heard and empowered through the actions both of the service that she is placed with and the team who work with her.
Situated knowledge: Considering the knowledge that is informing the actions of the care team in the above scenario, this service places a strong emphasis on the importance of education and on the importance of supporting Mary's relationship with her family. The practice of the team demonstrates the use of therapeutic interventions in how they support each of these components in Mary's life (see Byrne 2013 for an exploration of therapeutic social care practice). The team are tuned into Mary's likes and dislikes, her needs and wants, and her family dynamic. Such support will encourage Mary to maintain important relationships and to access her education.
Practice wisdom: In the case study above, the care team are relying on their knowledge of various theories, for example: Ainsworth (1978), Becker (1963), Biestek (1953), Bowlby (1969), Goffman (1959), Rogers (1961) and Winnicott (1960), and coupled with their experience of working with Mary (is intelligent, finds tea comforting, can only study/learn in a positive nurturing environment, family are important to her) to inform their approach so that Mary's needs are appropriately met in a way which is empowering and supportive.

The SKIP Model and the Standards of Proficiency for Social Care Workers

The eighty standards of proficiency for social care workers are the threshold standards of practice set by the Social Care Worker Registration Board for safe and effective practice. The standards of proficiency provide statements indicating the knowledge and skills that all those who enter the register as a social care worker must have (SCWRB 2017). Your degree programme has been carefully designed to ensure that every student will, when they graduate, have demonstrated their achievement of the standards of proficiency for social care workers. Across the higher education sector, the various institutes will have taken different approaches in how this is achieved. However, every programme is evaluated by CORU and is subject to ongoing monitoring and auditing by CORU to ensure that each student meets the threshold prior to graduation. All eighty proficiencies are relevant to the three categories of knowledge in the SKIP Model.

TASK 4

Select two proficiencies that relate to each one of the three knowledge categories:

1. What is social care?
2. How to do social care work.
3. The service user and his/her world.

Professional Skills in Evidence-informed Practice

As a social care student, you will need to demonstrate proficiency in the skills of evidence-informed practice. The SKIP Model is a framework providing examples of the knowledge underpinning social care work. Understanding and applying this model is confirmation of your skills in evidence-informed practice. Gambrill (2013) identified three key traits which, she argues, are necessary to effectively engage with and pursue evidence-informed practice. These are critical thinking, advocacy and clinical expertise. The SKIP Model has reframed clinical expertise into the section entitled Professional Expertise, and the other two skills – critical thinking and advocacy – are also ways to demonstrate your evidence-informed practice.

Critical Thinking

Gambrill (2013) argued that critical thinking is a key component to any practice that is based on evidence. According to Paul (1993), the specific intellectual traits that are essential for critical thinking to be effective are courage, integrity and perseverance. Finn (2011) suggests that there are four thinking styles that enhance the development of critical thinking capacity in workers:

- Open-mindedness – a disposition that is interested in finding new evidence, new ways of working and new ideas
- Fairmindedness – the capacity to take on board views, opinions and perspectives which may be in contradiction to one's own previously held beliefs
- Reflectiveness – the individual's willingness to take time to review any new information and to look at the advantages and disadvantages of each without accepting the first apparent solution
- Counterfactual thinking – the capacity to look at the research and the situation from a range of different perspectives and to endeavour to think through possible alternatives and outcomes.

TASK 5

Think of recent experiences where you practised (1) open-mindedness, (2) fairmindedness, (3) reflectiveness and (4) counterfactual thinking.

Advocacy

The second key trait is for the worker to be an effective advocate for their service user(s). There is consensus across the social care literature in Ireland that social care workers' advocacy role encompasses the promotion of the needs of the client (SCWRB 2017), ensuring that clients have access to an advocacy service (HIQA 2017) and a preparedness to advocate for resources and services subject to the needs of the client (Tusla 2016). Incorporated in the advocacy role is the need to ensure that the supports to empower service users are in place; for example, scheduling meetings in venues accessible by public transport or being aware of the need to avoid professional jargon in meetings. Service users may also rely on the interpersonal skills of social care workers to empower them to engage with other professionals or in certain situations (Evans & Kearney 1996).

TASK 6

1. Think of recent experiences where you were an advocate for a service user or family member.
2. Read Chapter 75 and Chapter 37 for more information on advocacy.

Social care knowledge is always evolving, building on the work and expertise of social care professionals and lived experiences of service users. The SKIP Model emerged from our own evidence-informed research, where we interpreted theories, concepts and the practice experiences of social care workers to enhance our work as educators. This model will also evolve and develop as we learn more. As a social care student this model may be useful to help you demonstrate your skills in evidence-informed practice.

Tips for Practice Educators

1. Ask the student to present the SKIP Model to the social care team, as a way of gathering information on the evidence different workers use to inform their practice.
2. To support your team to demonstrate their knowledge of and skills in evidence-informed practice (Standards of Proficiency for Social Care Workers), create environments for workers to discuss the evidence (knowledge and skills) used in their practice.
3. Give the student on placement a piece of action research to conduct under your supervision. Action research is an approach to research in which the worker is the researcher, and the research topic is an investigation into the worker's own practice. Workers examine what they do, why they do it and what results they hope to accomplish. The purpose of engaging in such research is to enable workers to create new theories regarding how the research has impacted on their personal practice. Through engagement in the process of action research, day-to-day work practices can become transformed into theories, thereby expanding the research in the field of residential care.
4. Critical thinking skills:

   The following tips are aimed to support students on placement to engage with Finn's (2011) four thinking styles.

   a) Open-mindedness – a disposition that is interested in finding new evidence, new ways of working and new ideas:

TASK 7

Read the blog by Carol Dweck, 'A Summary of Growth and Fixed Mindsets' (https://fs.blog/2015/03/carol-dweck-mindset/) and discuss the impact of the growth mindset on your thinking.

b) Fairmindedness – the capacity to take on board views, opinions and perspectives which may be in contradiction to one's own previously held beliefs:

TASK 8

Read Kendra Cherry's article 'Unconditional Positive Regard in Psychology' (https://www.verywellmind.com/what-is-unconditional-positive-regard-2796005) and consider how understanding self-worth develops a sense of fairmindedness.

c) Reflectiveness – the individual's willingness to take time to review any new information and to look at the advantages and disadvantages of each without accepting the first apparent solution:

TASK 9

Reflect on the impact of one theory on how you practise social care. Discuss why you chose this theory and how it applies to practice in your service.

d) Counterfactual thinking – the capacity to look at the research and the situation from a range of different perspectives and to endeavour to think through possible alternatives and outcomes:

TASK 10

Discuss one research idea at a team meeting, provide two different approaches and brainstorm the possible alternatives and outcomes.

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Chapter 68 – Lindsay Malone

Domain 5 Standard of Proficiency 7

Demonstrate an understanding of the theories of individual and social development across the lifespan and contexts and within different cultures including the knowledge required to work with individuals, children, vulnerable adults, families and marginalised groups

KEY TERMS

Nature versus nurture

Lifespan

Adverse childhood experiences

Social Care is … a relationship based approached to the provision of care in the lives of those who are marginalised or in need of additional support or protection.

TASK 1

Nature verses Nurture – Consider how we develop – is it because of our genetics and biology or is it because of our environment?

Introduction

This chapter will explore the theories of individual and social development across the lifespan and contexts and within different cultures. The information provided and the tasks have been developed in order to enable you to develop the knowledge required to work with individuals, children, vulnerable adults, families and marginalised groups. This proficiency is essential for social care practice as there is currently significant a focus on understanding trauma and how it links to theories of individual and social development.

Nature and Nurture

The narrative surrounding how individuals develop over their lifetime has its roots firmly based in the nature verses nurture debate. The naturalists understand development to be influenced by genetic inheritance whereas those on the nurture side of the debate consider development to be the product of exposure to life experiences (Levitt 2013).

Key Message

Physical and Cognitive Development occur in universal sequential stages

Gesell's Maturation Theory

Disequilibrium

4.5 years
- Sometimes acts like a 4, sometimes like a 5
- Insecure
- Emotionally changeable

3.5 years
- Needs to succeed/have own way
- Insecure
- Disobeys
- Clumsy, stumbles often
- Objects to eating, dressing routine

2.5 years
- Goes to extremes
- Can't make a choice
- Hates change
- Bossy, demanding, determined

18 months
- Difficult, impatient
- Frustrated when s/he can't communicate, cries or tantrums when not understood
- Can't make body do what s/he wants

Equilibrium

5 years
- Quiet and secure
- Wants to be good, usually is
- Likes the tried and true, not the new and strange

4 years
- Self confident, loves to be silly
- Willing to try anything wild
- Laughs and cries loudly
- Brags, swears and even lies

3 years
- Happy with the world
- Likes to obey
- Controls body well
- Proud of ability to feed and dress him/herself

2 years
- Pleasant, friendly, calm
- Talks more easily
- Controls body well
- Can cooperate

(Gesell Institute 2020)

From a naturalist perspective, In the early 20th century clinical psychologist and paediatrician Arnold Gesell developed Gesell's Maturation Theory. This theory focused on the physical and cognitive development of children. Gesell believed that children will go through the same stages of development, in the same sequence but each child will go through the stages at their own rate as patterns of development are determined by the individual's heredity. The core emphasis of Gesell's theory was that growth always progresses in a pattern through predictable stages whereby sequential development begins within the embryo and continues after birth (Couchenour & Chrisman 2016).

According to Gesell growth and development should be thought of as a cyclical spiral which alternates between patterns of equilibrium and disequilibrium, each cycle of the spiral encompassing the time it takes to move through six stages that alternate between equilibrium and disequilibrium. These cycles of development are divided into six definitive stages which are repeated throughout life. See figure below of the cycles of development (Couchenour & Chrisman 2016).

To further illustrate an example of how Gesell's theory of maturational development always unfolds in fixed sequences consider an embryo. The embryo's heart is always the first organ to develop, which is then followed by central nervous system and then followed by the peripheral organs. Continuing with the sequential stages, following birth, a baby will first gain control over their mouth, followed by eye movement, followed by control over their neck, shoulders, arms, legs, and feet. Once the baby further develops, they learn to sit up, stand, walk, and run; these capacities develop in a specific order with the growth of the nervous system, even though the rate of development may vary from child to child. Gesell believed that individual differences in growth rates are a result of the internal genetic mechanisms (Lerner 2015).

Maturational theory states that while the child's social and cultural environments also play a role in their development, these socializing forces are most effective when they are harmonious with the inner maturational timetable. Maturation is the genetically programmed sequence of change that individuals all go through in life. Gesell fundamentally believed development is predetermined, with little influence from the environment. If a child experiences delayed development, then the problem is heredity not environmental.

Key Message

Cognitive Development happens in sequential stages

Piaget's Theory of Cognitive Development

Offering another way of looking at development through sequential stages, Jean Piaget developed his theory of cognitive development which suggests that individuals progress through four developmental stages: the sensorimotor, preoperational, concrete operational and formal operational period. Focusing on cognitive or mental development, the theory offers an explanation of the nature of knowledge itself and how individuals gradually acquire, construct, and use it (Piaget 1972).

Sensorimotor Stage

The first stage is the Sensorimotor stage, which covers birth to two years. In this stage, children seek to understand objects in the world around them by using sensory activity. The key milestones here are object permanence and deferred imitation. The former being the child's ability to know that objects remain in the environment even when they cannot see them and the latter meaning the child's ability to imitate others (Piaget 1972).

Critical Lens

According to the findings from Bauer et al. (2019) cognitive abilities amongst infants can develop much sooner than Piaget inferred.

Preoperational Stage

The second stage is the preoperational stage which covers two to seven years of age. This stages focuses on symbolic ability which is the child's ability to use symbols and words to understand the world around them. Two core components of this stage are animism and egocentrism. Animism occurs when children believe everything in the world around them is alive, including inanimate objects. An example of this evident when a child will not leave a teddy bear outside at night time as the child believes the teddy will be cold and lonely outside on its own. Egocentrism refers to the child's inability to see a situation from another person's point of view as they believe that others see, feel and experience things in the same way they do (Piaget 1972).

Critical Lens

A study by Gelman (1972 cited in Berk 2006) revealed that children aged 3 could perform the conservation task successfully which proves Piaget's theory incorrect and demonstrates that Piaget underestimated the ability of pre-school children.

TASK 2

You can view the Three Mountains Task which examined Egocentrism here: Three Mountain Task

Operational Stage

The third stage is the concrete operational stage which spans from the age of seven to eleven. The key milestones of this stage are conservation and classification. The former is the child's conservation abilities, in other words, they develop the ability to understand that a litre of water remains the same

in different sized glasses. During this stage they also develop the ability to classify objects into different sizes, shapes and value. They also develop the ability to understand sets and subsets, for example that a mother can be a sister and daughter all at the same time (Piaget 1972).

Critical Lens

Research by Comer et al. (2011) revealed that children in this stage cannot understand the relationship between things that do not exist in the physical world.

Formal Operational Stage

This final stage occurs from the age of eleven into adolescence and is defined by significant development in the child's thinking and reasoning skills whereby they develop the ability to use logic and abstract reasoning (Piaget 1972).

Critical Lens

Research by Bernstein et al. (2008) revealed that not all adolescents acquire this ability as in some societies only half do due to educational disadvantages

TASK 3

Consider whether Piaget's theory is a true reflection of all children and young people or is it culturally specific?

The Social Care Workers Voice

"I use Piaget's Theory all the time in practice as it helps me to understand the normative stages of development. By having an understanding of normative milestones, it becomes easier to see when a child may be experiencing developmental difficulties. For me, the theory provides a roadmap of development milestones which I can use to support and scaffold a child's learning and development" (School Completion Officer 2020)

Key Message

There are 4 types of Attachment and each have an impact on a person's behaviour

Attachment Theory

Attachment is a bond from one person to another which lasts a lifetime. The evolutionary Theory of Attachment originates from Bowlby (1958). According to Bowlby, infants have a universal need to seek closeness when they feel threatened and attachment occurs when the caregiver provides safety and security for an infant. Essentially, from a nature perspective, infants are biologically predisposed to form attachments and from a nurture perspective, how the caregiver responds is vital in how it forms. Bowlby defined the following four stages of attachment.

Pre-attachment (Birth - 2 months) Baby shows no particular attachment to any caregiver	**Indiscriminate (2 - 6 months)** Infant begins to show preference for primary caregivers
Discriminate (7 months +) Infant shows attachment to one primary caregiver	**Multiple (10months +)** Infant develops bonds with other caregivers

TASK 4

Watch Ainsworth Strange Situation Video Here: Ainsworth Strange Situation Video

Building on Bowlby's work, Mary Ainsworth devised an assessment technique called the Strange Situation Classification in order to investigate how attachments might vary between children. Observing infants aged between 12 and 18 months covertly, the experiment sample comprised of 100 middle-class American families where the behaviour of the infant in a series of eight episodes lasting approximately 3 minutes each was measured. From the findings, Ainsworth (1970 cited in Brown and Ward 2013) identified three main attachment styles, insecure avoidant (type A), secure (type B), and insecure ambivalent/resistant (type C) and a fourth attachment style known as disorganised was later identified. She concluded that these attachment styles were the result of early interactions with the caregivers and the results can last a lifetime.

Secure attachment occurs when the child is cared for by sensitive and responsive caregivers. Securely attached children are able to regulate their distress and know they can show their needs and feelings and won't be rejected.	**Insecure avoidant** tends to occur when the caregiver finds it difficult to accept or respond sensitively to the infant's needs. These children tend to experience parenting that is hostile, rejecting and controlling. They come to see themselves as neither loved nor loveable. Children respond to this by shutting down on their feelings because of their anxiety that any display of need or emotion may drive their caregiver away.
Insecure ambivalent attachment tends to occur when the caregiver responds inconsistently to the child's demands. These children exaggerate their attachment behaviour to attract attention. They are not always successful at being noticed and their ambivalence reflects their need for and anger with their attachment figure.	**Disorganised** attachment occurs in children who are cared for by people who are frightening. Children may fear approaching their caregiver because they cannot predict whether they will respond positively or negatively. Consequently these children are not able to 'organise' their own behaviour and have difficulty regulating their emotions.

(Brown and Ward, 2013)

The Social Care Workers Voice

"Understanding attachment theory is vital in my role as a Residential Social Care Practitioner as our referrals are awash with the word attachment. Therefore, to not understand the different types of attachment, would be detrimental to how we engage, support and care for young people in our unit. Understanding attachment theory also enables me to understand how the life history of a young person has played an important role in how they behave now" (Residential Social Care Worker 2020).

Thus far consideration has been given to the naturalist views of development. From here, the discussion will move more to the nurture side of the debate.

Social Learning Theory

TASK 5

Watch Bandura's Bobo Doll Experiment here: Bobo Doll

Bandura's Theory of Social Learning suggests that people learn through observing how people behave in the world around them. More specifically, individuals that are observed are called models. In society, people are surrounded by many influential models, such family, friends, the media etc. These models provide examples of behaviour to observe and imitate, e.g., masculine and feminine, pro and anti-social, etc. Children pay attention to models which enables them to encode their behaviour so that they can imitate the behaviour they have observed. This is illustrated during the famous Bobo doll experiment (Bandura et al. 1961).

Social Learning Theory also infers that observational learning only occurs because cognitive processes are at work. These mental factors intervene in the learning process to determine whether a new response is acquired. Thus, individuals do not automatically observe the behaviour of a model and automatically imitate it. This is because thoughts occur prior to imitation, and this consideration is called mediational processes. This process occurs in between when the individual observes the behaviour (stimulus) and when they imitate it or not (response). There are four mediational processes proposed by Bandura as outlined below.

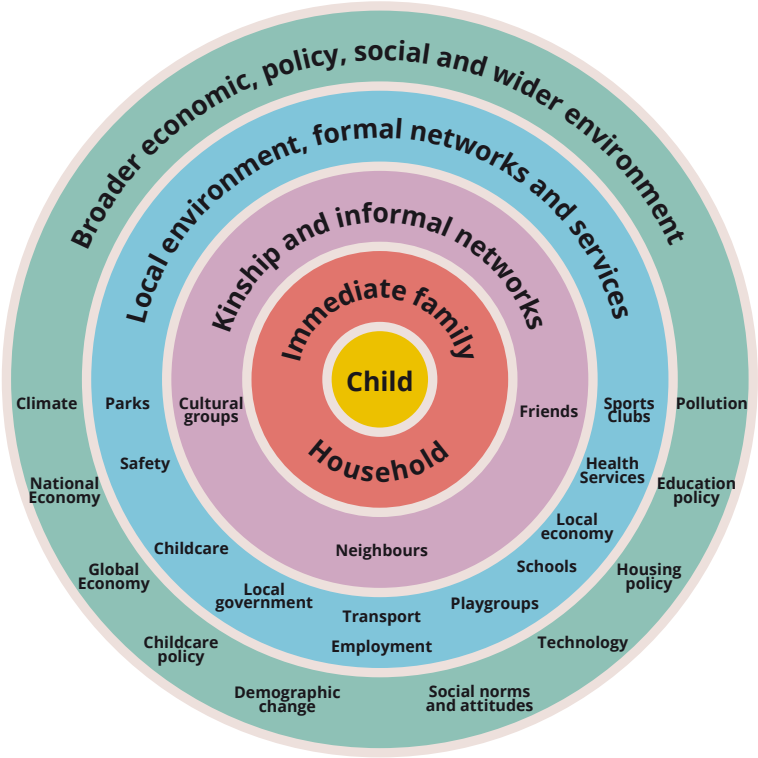
Attention: The extent to which an individual is exposed to a behaviour. For a behaviour to be imitated, it has to grab their attention. Attention is therefore extremely important in whether a behaviour influences others imitating it	**Retention:** How well the behaviour is remembered. The behavior may be noticed but is it not always remembered which prevents imitation.
Reproduction: This is the ability to perform the behaviour that the model has just demonstrated. People are limited by our physical ability and for that reason, even if they wish to reproduce the behaviour, they cannot.	**Motivation:** The will to perform the behaviour. The rewards and punishment that follow a behaviour will be considered by the observer. If the perceived rewards outweigh the perceived costs, then the behaviour will be more likely to be imitated by the observer.

Key Message

The direct and indirect environment around the individual shapes their development

Bronfenbrenner's Ecological Systems Theory

Continuing with the focus on how the environment can shape a person's development, Bronfenbrenner's Ecological Systems Theory depicts five ecosystems. Bronfenbrenner believed that a person's development was affected by everything in their surrounding environment. He divided the person's environment into five different levels: the microsystem, the mesosystem, the exosystem, the macrosystem, and the chronosystem (Bronfenbrenner 1979).



(Gibbs 2016).

TASK 6

Using the case studies below, apply Bronfenbrenner's Theory to John, Mary and Florence's lives in order to examine their ecosystems and how they affect their development

Case Study 1

John is 15, he has Autism Spectrum Disorder and lives in Residential Care. He has two younger brothers who are in Foster Care. John's mother is in prison and John's father is deceased. John sees his brothers every second weekend. John is on a reduced timetable at school and is engaging with the School Completion Programme, as he is at risk of leaving school early. The Residential Unit is based in a small rural village which is close to John's school, so he walks to school with friends.

Case Study 2

Mary is 37. Mary is in active addiction and is homeless. Mary has two children who are in Foster Care. Mary does not currently see her children. Mary has a partner who is also in active addiction.

Case Study 3

Florence is a 28 year old Refugee with two young children. Florence is living in direct provision and is working with a keyworker in order to reach her goal of finding employment and a home of her own.

Key Message

Development continues over the life span and this occurs over a series of stages

Erikson's Theory of Psychosocial Development

Erikson's Theory of Psychosocial Development suggests that personality develops in a predetermined order through eight stages of psychosocial development, from infancy to adulthood. During each stage, the individual will experiences a psychosocial crisis which could have a positive or negative outcome for personality development. For Erikson (1959), these crises are of a psychosocial nature because they involve psychological needs of the individual (i.e., psycho) conflicting with the needs of society (i.e., social). According to the theory, successful completion of each stage results in a healthy personality and the acquisition of basic qualities. Basic qualities are characteristic strengths which the ego can use to resolve subsequent crises. This theory is further illustrated below.

Age and Stage	Crisis	Explanation
Infancy: Birth-18 Months Old	Basic Trust vs. Mistrust – Hope	The major emphasis is on the caregivers nurturing ability and care for a child, especially in terms of visual contact and touch. The child will develop optimism, trust, confidence, and security if well cared for and handled. If a child does not experience trust, he or she may develop insecurity and general mistrust to the world.
Toddler/ Early Childhood Years: 18 Months to 3 Years	Autonomy vs. Shame – Will	At this point, the child has an opportunity to build autonomy as they learn new skills and right from wrong. The well-cared for child is sure of himself, carrying themselves with pride rather than shame. Children tend to be vulnerable during this stage, sometimes feeling shame and low self-esteem during an inability to learn certain skills.
Pre-schooler: 3 to 5 Years	Initiative vs. Guilt – Purpose	During this stage the child will experience a desire to copy the adults around them and make up stories through imaginative play. This enables the child to play out roles in a trial universe, experimenting with the blueprint for what we believe it means to be an adult. The most significant relationship is with the basic family.
School Age Child: 6 to 12 Years	Industry vs. Inferiority – Competence	During this stage, the child is capable of learning, creating and accomplishing numerous new skills and knowledge, thus developing a sense of industry. This is also a very social stage of development and if we experience unresolved feelings of inadequacy and inferiority among our peers, they can experience serious problems in terms of competence and self-esteem. The most significant relationship is with the school and neighbourhood.
Adolescent: 12 to 18 Years	Identity vs. Role Confusion – Fidelity	Up until this fifth stage, development depends on what is done to a person. At this point, development now depends primarily upon what a person does. An adolescent must struggle to discover and find their own identity, while negotiating and struggling with social interactions and "fitting in", and developing a sense of morality and right from wrong. Some attempt to delay entrance to adulthood and withdraw from responsibilities (moratorium). Those unsuccessful with this stage tend to experience role confusion and upheaval. Adolescents begin to develop a strong affiliation and devotion to ideals, causes, and friends.
Young adult: 18 to 35	Intimacy and Solidarity vs. Isolation – Love	At this stage, people tend to seek companionship and love. Young adults seek deep intimacy and satisfying relationships, but if unsuccessful, isolation may occur. Significant relationships at this stage are with marital partners and friends.

Age and Stage	Crisis	Explanation
Middle-aged Adult: 35 to 55 or 65	Generativity vs. Self absorption or Stagnation – Care	Career and work are the most important things at this stage, along with family. Middle adulthood is also the time when people can take on greater responsibilities and control. For this stage, working to establish stability and Erikson's idea of generativity – attempting to produce something that makes a difference to society. Inactivity and meaninglessness are common fears during this stage. Major life shifts can occur during this stage. For example, children leave the household, careers can change, and so on. Some may struggle with finding purpose. Significant relationships are those within the family, workplace, local communities.
Late Adult: 55 or 65 to Death	Integrity vs. Despair – Wisdom	Erikson believed that much of life is preparing for the middle adulthood stage and the last stage involves much reflection. As older adults, some can look back with a feeling of integrity – that is, contentment and fulfilment, having led a meaningful life and valuable contribution to society. Others may have a sense of despair during this stage, reflecting upon their experiences and failures. They may fear death as they struggle to find a purpose to their lives.

(Erikson 1959)

TASK 7

Reflecting on Erikson and Bronfenbrenner's theories, consider how the 8 stages from infancy to late adulthood relate to Bronfenbrenner's ecosystems – can you link the ecosystems to each of the 8 stages?

Adverse Childhood Experiences

Key Message

Adverse Childhood Experiences have lasting effects and can be prevented

Studies are increasingly identifying the importance of early life experiences to people's health throughout the life course. Individuals who have Adverse Childhood Experiences (ACEs) during childhood or adolescence tend to have more physical and mental health problems as adults than those who do not have ACEs. ACEs that affect children directly include abuse and neglect. Indirectly, ACEs may occur through their living environments e.g., parental conflict, substance abuse, or mental illness.

More specifically, ACEs, are potentially traumatic events that occur in childhood (0-17 years). For example:

- experiencing violence, abuse, or neglect
- witnessing violence in the home or community
- having a family member attempt or die by suicide

Also included are aspects of the child's environment that can undermine their sense of safety, stability, and bonding such as growing up in a household with:

- substance misuse
- mental health problems
- instability due to parental separation or household members being in jail or prison

ACEs are linked to chronic health problems, mental illness, and substance misuse in adulthood. ACEs can also negatively impact education and job opportunities. However, ACEs can be prevented (Centre for Disease Control and Prevention 2020).

There is a significant body of evidence available on the benefits of early intervention in the lives of children (Lacey and Minnis 2020). Early intervention in children's lives when there are difficulties can prevent problems escalating, strengthen families' capacity to nurture children, and encourage and enable families to solve their own problems. Early intervention and improved cooperation, means that apparent difficult issues can be dealt with quickly and effectively, getting a full picture of a child's circumstances and getting appropriate people involved early. The role of prevention is not only to combat risk factors but also to enhance and promote the positives in a child's life as well as opportunities for child development. Changing the balance between risk and protective factors so that protective factors outweigh risk factors is an effective prevention and early intervention strategy (Tusla 2020).

TASK 8

Examine the findings from CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study. This is one of the largest investigations of childhood abuse and neglect and household challenges and later-life health and well-being: ACE Case Study

Conclusion

This chapter has explored the key theories of individual and social development across the lifespan and contexts and within different cultures. The information and tasks provided have been developed in order for you to enhance your knowledge and understanding of these key theories in order to underpin your practice. This chapter has been designed to addresses Domain 5 Standard of Proficiency 7 in order to support you demonstrate an understanding of the theories of individual and social development across the lifespan and contexts and within different cultures including the knowledge required to work with individuals, children, vulnerable adults, families and marginalised groups.

Tips for Practice Educators

This proficiency is best understood for many students in the context of observations on practice placement.

- Provide the student with opportunities to observe practice where your agency demonstrates theories of individual and social development in interactions/engagement with service users.
- Suggest that students use their reflective diary to record their understanding of the application of this proficiency in practice.
- Provide an opportunity where students can plan activities and tasks that demonstrates their understanding of the importance of social development,
- Help students to plan strategies that ensure service users have a opportunity to reach their potential.
- Explore with your student in supervision their understanding or experiences of ACE.
- Support the student in identifying possible programmes/activities from their academic studies, that may support a service user with ACE.

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Chapter 69 – Denise Lyons and Sharon Claffey

Domain 5 Standard of Proficiency 8

Understand the role and purpose of building and maintaining relationships as a tool in the delivery of social care across the lifespan in a variety of contexts.

KEY TERMS

Variety of contexts

Relationship-based social care work

Building and maintaining relationships

Social care is … relationship-based practice that involves having a non-judgemental attitude, being consistent in using a strengths-based approach and, in turn, empowering people to reach their full potential.

Five proficiencies of the eighty are about relationship, referring primarily to the relationship between the worker and the service user (Chapters 35, 36, 69 and 70); the professional relationship with colleagues (Chapter 38) is also acknowledged and valued.

Domain	Chapter in this book	Focus on the Relationship
D2 SOP12 **(2017: 6)**	Ch 35 by Natasha Davis	*'Be aware of the concepts of power and authority in **relationships with service users'***
D2 SOP13 **(2017: 6)**	Ch 36 by Des Mooney	*'Understand the need to build and sustain professional relationships'* **(with everyone)**
D2 SOP15 **(2017: 6)**	Ch 38 by Des Mooney	*'Understand the role of relationships **with professional colleagues** … based on mutual respect and trust'*
D5 SOP9 **(2017: 9)**	Ch 70 by Teresa Brown	*'Critical understanding of **the dynamics of relationships'*** (with service users), focusing on 'concepts of transference and counter-transference'

This chapter focuses on explaining the role and purpose of relationships through a discussion on relationship-based social care work, concluding with practical recommendations on how to build and maintain relationship across the lifespan and within different contexts.

Variety of Contexts

Social care workers build and maintain relationships with children and/or adults, through the delivery of care across a variety of social care services. Depending on the nature of the service and the needs of the service users, this relationship may be short and focused, or long and spanning several years, or a full life-time, terminated only by the death of the service user or the retirement of the worker. The context, the social care setting, will determine the length of time and the quality of access the worker has with the service user. McCormack *et al.* (2002: 94) state that 'context specifically means the setting in which practice takes place'. Context is also defined as the background for all social interactions which are influenced by cultural, historical, political and economic constructs (Burr 2015). However, context is more than a backdrop; context is a social, active and emergent space (Wenger 2010), shaped by the relationships within. Therefore, context is practice (Barnett 1999), people, structures and relationships. Social care services are always in a state of flux, changing to meet the diverse needs of service users, adapting to new people, and adjusting to the current economic and political climate. The context is the physical representation of how the practice is influenced by policy and valued by society. These socially constructed and ever-changing contexts are places that are meaningful (Tuan 2012) and spaces that are lived-in and loved (Merleau-Ponty 2012).

Social care workers inhabit the contexts of practice; they engage in the activities and movements of social care, through their holistic and embodied practice, from physically pushing a wheelchair or using a hoist, sitting beside someone in the shared space, to cognitively and emotionally 'being present' (Digney & Smart 2014). The contexts of practice are diverse, and each worker is engaged in completely different activities depending on the needs of the service user in that place, space and time. The discussion on varied contexts of care requires some understanding of the concepts of place and space (Lefebvre 1991). McDowell (1996: 29) articulated a relational definition of space, where 'all social relationships occur somewhere and result in connections between people and places'. Place is presented as the 'nodes' of space, a 'symbol' of space that is ascribed with 'personality and spirit ... the sense of place' (Tuan 2012: 388-9). The personality of a place is felt, remembered with affection or hate, and recollected from a smell (Tuan 2012), taste or photograph. Workers and service users shape the varied contexts of social care practice and are ultimately shaped by them.

The theory of material culture, which studies the relationship between people and objects, is also relevant to understanding the impact of social care contexts (Hicks & Beaudry 2010) on people, relationships and practice. The material culture of contemporary social care (Woodward 2007) includes the objects and practices of everyday life in the different settings. This includes, but is not limited to the furniture, decorations, utensils, fabrics, and also the objects used to provide care; the wheelchairs, hoists, slings, medicine cabinets, the locked press, the keys, the office and the records, to name a few (Hicks & Beaudry 2010). Material culture also includes the remnant artefacts from the past which continue to influence the use and feel of the space, from the architecture of the building, including the location of the setting, to the size of the rooms, the previous use of the space, and the dated photographs that adorn the walls (Davies *et al.* 2013). Within these buildings converted into social care settings, social care workers, through relationship-based practice, give life to ordinary places for meaningful practice.

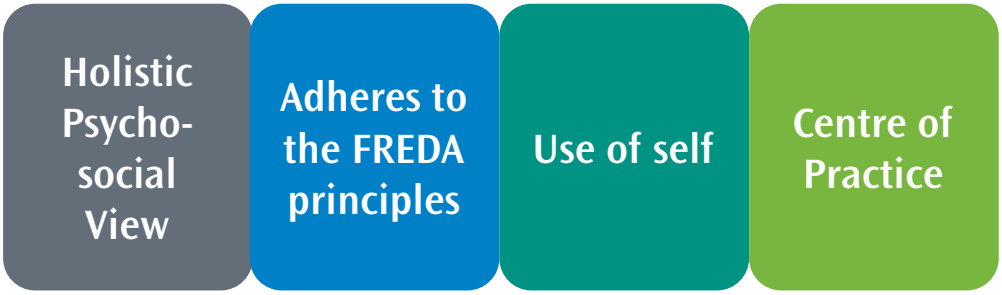
TASK 1

Think of a social care setting, focusing on the building itself. Did it feel homely, clinical, warm or cold? How did the 'context' and its 'material culture' make you feel?

Relationship-based Social Care Work

As the view of the relationship in SCWRB's 'standards of proficiency' is presented as a threshold, social care needs a theoretical frame underpinning the knowledge base that presents the relationship as core and central to practice (Lyons 2017). Scholarly discourses on the relationship in social work, social pedagogy and child and youth care (Garfat 2004, 2008; Stephens 2013; Egan 2014) have influenced social care workers and educators in Ireland (McHugh & Meenan 2013; Lyons 2009, 2013; Digney & Smart 2014). The various relationship approaches may differ slightly in position and context, but all involve one person engaging with another while they are doing things together and being with each other. Trevithick (2003: 163) presented a history of how the relationship, once seen as essential for best practice, had fallen 'out of favour', which led to the revisionist 'relationship-based social work' framework. The characteristics of this framework (Wilson *et al.* 2011) are relevant to the relationships in social care work and form part of the four core characteristics discussed in this chapter. The relationship-based social care work framework presented here is influenced by Wilson *et al*. (2011), the Standards of Proficiency for Social Care Workers (SCWRB 2017) and the perspectives of social care workers in Ireland (Brown 2016; Lyons 2007, 2017).

4 Characteristics of Relationship-based Social Care Work



In relationship-based social care work, workers begin to understand a person through the sharing of a life story. Stories about the past, and present experiences, help us 'to understand oneself and others' (Chamberlayne *et al.* 2000: 7). Through listening empathically to others, we can learn how they became who they are and 'understand our own histories and how we have become who we are' (Chamberlayne *et al*. 2000: 7). The following case study was extracted from two chapters in Howard and Lyons (2014) *Social Care: Learning from Practice.* The two chapters (Fenton 2014; King 2014) are based on the relationship between the social care worker (Maurice Fenton) and a young person in residential care (Keith King). Segments from the two chapters are presented here as examples of the four characteristics of relationship-based social care work. Although relationships take time to develop (Lyons 2017), Keith and Maurice's relationship in the children's residential centre lasted approximately five months.

1. Holistic Psychosocial View

All people are unique and therefore our relationships with them are different from all other relationships we have developed and experienced. The people we work with are complex and multifaceted and relationship-based social care work accepts that people are influenced both by the internal world of feelings, emotions and behaviours, and also by the external world, including their past experiences and how they are treated by society, policy and the people around them (Wilson *et al.* 2011). This is a psychosocial approach (Newman & Newman 2012) to social care work that acknowledges the interaction between biological, psychological and societal systems and their influence on the service user. 'Holistic' refers to the relationship of the whole person (body and mind) of the worker with the whole person (body and mind) of the service user. We need to know people well in order for them to be comfortable with us, physically, emotionally and cognitively. Social care practice is the embodiment of both the worker and the service user in the shared space of practice; we work and live together. 'Head, heart and hands signifies this holistic approach' (Ghate & McDermid 2016: 6) and 'all three being essential for the work' (Petrie *et al.* 2006: 4). We can apply a holistic, psychosocial approach within our relationships with others by learning about them through their story.

Case Study 1

Keith was born into a large family 'that suffered physically, socially and psychologically through domestic violence and alcoholism' (King 2014: 37). Keith's parents were loving when alcohol was not involved, and he learned to read their mood and level of intoxication by their body language and dress. Keith had a reputation in school and local community as a thief (explained in his chapter) and spent large amounts of time without adult supervision or care.

Fenton (2014: 48-49) described Keith's focusing on the positives in his relationship with Maurice and with his mother, as Keith's way of "distinguishing the love from the harm". Maurice understood Keith's need to 'act in socially unacceptable ways' as a response to childhood trauma and a need to survive. Keith presented with a 'range of complex and challenging behaviours', which Maurice understood as communicating trauma and he responded with kindness, care, patience and trust, which had an emotional and long-lasting impact on Keith.

2. Adheres to the FREDA Principles

The FREDA principles (Curtice & Exworthy 2010), which were adopted by the Health Information and Quality Authority (HIQA 2019), are fairness, respect, equality, dignity and autonomy. They represent the values within the relationship-based social care relationship.

Case Study 2

Keith noted how Maurice 'made a massive impression' on his life (King 2014: 40) and that he knew he could trust him because he experienced ***equality*** when Maurice 'always stood up and advocated for me'. Keith experienced ***respect*** when Maurice showed genuine interest in him and his needs. Keith experienced ***fairness***, ***dignity and autonomy*** when he felt heard, listened to and nurtured by Maurice. Also, when the manager of the unit genuinely apologised to him for making a mistake in the way she had spoken to him.

TASK 2

Please read HIQA's *Guidance on a Human Rights-based Approach in Health and Social Care Services* (2019) and list examples of times Keith was shown equality, respect, fairness, dignity and autonomy.

3. Use of Self and Body

Relationship-based social care work acknowledges role of self in practice including the body and the mind. Relationship-based practice in social care is holistic and embodied, a mutual collaboration between the worker and service user, centring on being supportive, and working within the relationship (Cameron & Moss 2011). Johnson (1987) described embodiment as involving the whole body in meaning-making within practice. Social care work is embodied through the lived experience, decision-making, and all the movements and practices of the people we work with and the services we work in. Social care workers have 'a body' (Johnson 1987) 'through which [they] act in the world' of practice (Merleau-Ponty 2012: 140). Workers also have a mind, which is engaged in being present and thinking about how to care for the person; and hands, used in physically supporting them to meet their needs. Embodiment for social care workers is not just about the engagement of the body, the thoughts and feelings connected to practice, but the overall experience of being in the world.

Case Study 3

When Keith entered residential care, he was introduced to the man (Maurice) who would become his key worker. Keith recognised him immediately as the man he had observed playing naturally with another child and noted he was kind and caring; he felt he could trust him. Maurice was using his authentic self (Brown 2016) in his play and care, which is a part of his relationship with the children in his care. Maurice described this as a 'willingness to show vulnerability and appropriately admit mistakes' and to show 'unconditional positive regard' (Fenton 2014: 50-2). Maurice made sure that Keith knew that he liked him and enjoyed spending time with him and was invested in their relationship. Keith experienced this as trust.

When we have a relationship with another person, we share a part of ourselves, and we also put at risk our emotional self (Clarke 2003; Lyons 2013). Potentially, there is pain in relationships, especially when the worker has become emotionally involved in trying to create an experience that is genuine, warm and real (McMahon 2010). Workers are challenged in their training and practice to adopt the values and beliefs of unconditional positive regard and empathy (Lalor & Share 2013) for the service users (Payne *et al.* 2009). But helping and supporting people can be emotionally difficult and challenging for the worker and workers need to recharge with self-care and learning how to switch off and resist bringing work (feelings, thoughts and concerns) home.

4. Relationship is the Centre of Practice

Relationship-based social care work is the centre of all interventions in planned practice, and the service user is the centre of everything. In Chapter 67, the SKIP Model (Lyons & Reilly, forthcoming), describes the relationship as the heart of evidence-informed practice in social care work. Social care workers learn 'what social care work is' within their specific setting, how to 'do' social care work in order to meet the needs of the people using the service through the relationship. The relationship is the core of social care practice in all settings (Kennefick 2006; Lyons 2009). Workers provide care and nurturing, demonstrate meaning and create meaningful moments (Digney & Smart 2014) and establish trust by being genuine and consistent (Howard & Lyons 2014). Social care work involves getting to know a person and sharing your time, experience, knowledge, humour, values, feelings and emotions with them. During the time you spend with the service user, information is being communicated, non-verbal and/or verbal, from you and between you. By viewing the relationship as the centre of practice, organisations will value and support the time needed to develop a relationship.

TASK 3

Read the two chapters and find more examples of the four characteristics of relationship-based social care work within the text.

Fenton, M. (2014) 'The Impossible Task: Which Wolf will Win?' in N. Howard and D. Lyons, *Social Care: Learning from Practice* (pp. 48-59). Dublin: Gill and Macmillan.

King, K. (2014) 'There's no Place Like Home: Care and Aftercare' in N. Howard and D. Lyons, *Social Care: Learning from Practice* (pp. 37-47). Dublin: Gill and Macmillan.

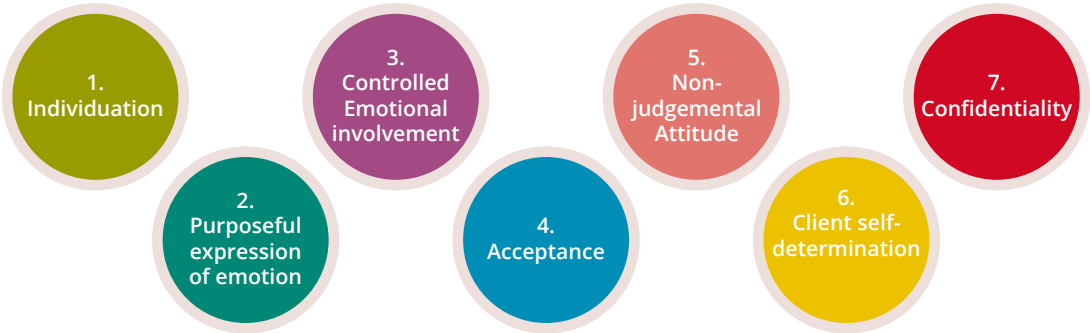
Building and Maintaining Relationships

This section of the chapter outlines the steps required for building and maintaining relationships. The first step encourages the worker to take a step back, ***look inwards*** and examine their own values and attitudes, step two, ***establishing rapport***, is the 'getting-to-know-you' phase, which moves to step three – the ***'relationship dance'*** between the worker and the service user.

Step 1 – Look Inwards

The skills in building a relationship with others begins with the worker, and the attitudes, values and beliefs they hold about people. *The Casework Relationship* by Felix Biestek (1957) has seven principles which outline the appropriate values, attitudes and knowledge needed before you start to build a relationship with a service user. Although this theory was published in 1957, and was part of my own social care education in the 1990s, it is still relevant today.

The Casework Relationship by Felix Biestek (1957)



'As with all practice approaches, a great deal depends on the knowledge, skills, values and qualities that' social care *'workers bring to the work'* (Trevithick 2003:164). The seven principles are difficult to achieve and require a commitment to consistently reflect and check in on your attitudes and beliefs and update your knowledge on how to become more empathic and less judgemental in practice.

TASK 4

Watch the video on the Seven Principles of the Casework Relationship: https://www.youtube.com/watch?v=IAF2TU93gpI

Write down the key steps involved in each principle.

Step 2 – Establish Rapport

The aim of the first stage of building a relationship is to help the service user to feel relaxed and safe in your company. You are not trying to 'do' in this stage but aiming to 'be' your genuine self (Kroll 2014). Start by learning the names of all the service users you will encounter daily, then give yourself the task of remembering one important fact about each person. You may be tested by the service user at this stage of relationship building, so take a mental note of all their likes and dislikes, what team they support, what music they like, if they take sugar in tea or where they like to sit. By mirroring and matching the service user, by folding your arms if they have folded their arms (mirroring) or folding your legs if they have folded their arms (matching). As you tune into the person's rhythm (Garfat & Fulcher 2012), their breathing and speaking, and use of space, you will help them to feel heard, seen and valued. Remember, every person is unique, so relax, watch, listen and learn.

Step 3 – The Relationship Dance

As you begin to establish familiarity with each other the relationship moves from the 'establishing rapport' stage to the 'relationship dance'. Kroll (2014: 73) called this stage the 'coming together stage' where communication is received and responded to, people are tuning in to each other, and a safe holding space is created, where 'taking risks can be thought about'. The following vignette from Garfat (2004) explains the 'dance of the unknowns', where the relationship is new and they dance betwixt and between this liminal and unknown space within the developing relationship.

> 'We don't know her, so we tread gently; we are unsure how to be so we move to our neutral therapeutic place and reach out tentatively, exploring, like her, the unknown territory. And because we move gently, we avoid any provocation which might cause a reaction. So, if this is correct, here we are, us and the young person, exploring the territory together, reaching out to see how the other will respond, finding out what is safe, how we can be here, what works. It is the 'dance of the unknowns', and it continues until one of us pushes a little more, moves to test the reality of her perceptions, reaches beyond the superficial safe place we establish in the early stages of relationship development. And in this, it is all so normal. We explore who this new person is; we explore how they are with us; we explore whether or not we are interested in taking this relationship to a different depth. We test. We move closer and move back. We explore' (Garfat 2004).

In this dance, *'the experiences, feelings and expectations that both participants bring into the relationship, the way in which connecting biographies play their part, and the defence mechanisms that come into play'* (Kroll 2014: 73) become the steps we navigate together. This unknown space in the dance is defined as the 'safe uncertainty' stage of relationship development in relational child and youth care (Featherstone *et al.* 2014). 'Preparation, making a warm, human connection, empathy, sympathy and intuition' (Kroll 2014: 78) are the ingredients needed to create safety and establish trust. Emotional intelligence is essential to read the dance and to respond appropriately, and to know when to apologise when you get the steps wrong. Sometimes relationships are difficult and experienced as 'stumbling through' (Hingley-Jones & Ruch 2016), especially if the person does not trust or know the staff member, or is dealing with their own issues. Ormond (2014) argues that even though the work can be very difficult and sometimes threatening, it is very important to relate to others in a non-blaming way, and 'survive' the work without becoming vindictive. He advises workers to be slow to judge, quick to use humour, and to become less self-conscious (Ormond 2014).

To conclude, relationship-based social care work is a useful framework to help workers remember that the relationship is the centre of our practice. This approach acknowledges the role of self, the uniqueness and complexity of the people we are building relationships with and how they are influenced by the systems that surround them, and finally, how the FREDA principles (Curtice & Exworthy 2010) will help us remember to treat people with respect and dignity. We can learn how to build and maintain relationships by becoming more aware of our own values and beliefs, learning techniques to establish rapport and developing our emotional intelligence so that we can understand the subtle communication cues and steps to help us to 'dance' and ultimately make a difference in one person's life.

Tips for Practice Educators

As building and maintaining relationships is the 'nuts and bolts' of your social care practice:

1. Share your knowledge on how to establish rapport with the service users in your unit. Do you mirror or match in your body language and gestures?
2. Ask the student to learn the names of all service users and at least one piece of information that is relevant and important to them.
3. In the relationship dance, talk about relationships that you found challenging and discuss with the service user the ways you worked this through.
4. Do a relationship chart of the service that outlines:
   a. The length of time people have used the service and worked there.
   b. The people who used to live or work there.
5. Ask questions about the building, what changes have happened over the years and how have these changes impacted on the services and the 'feel' of the building.
6. Review the seven principles of the casework relationship. Discuss how you apply individuation, purposeful expression of emotion, controlled emotional involvement, acceptance, non-judgmental attitude, recognise client self-determination and adhere to confidentiality in your relationships with the service users.

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Chapter 70 – Teresa Brown

Domain 5 Standard of Proficiency 9

Have a critical understanding of the dynamics of relationships between social care workers and service users and the concepts of transference and counter-transference.

KEY TERMS

Dynamics
Practice environment
Transference and counter-transference
Support/supervision
First voice

Social care is … a profession where we endeavour to work in solidarity, no them and us. It is a relationship based on respect and empathy.

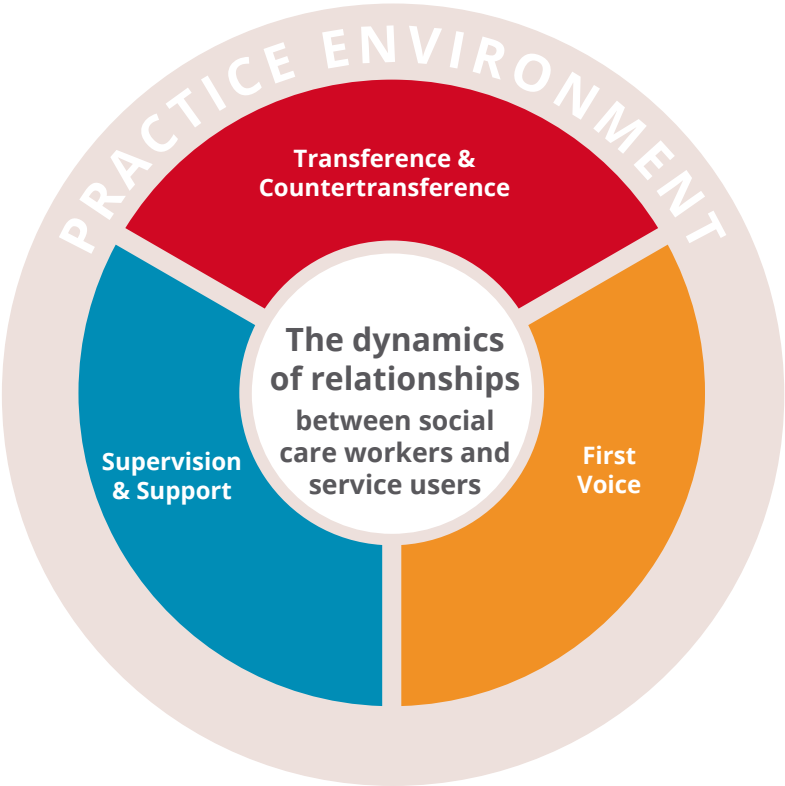
Dynamics

A consistent area of agreement in social care practice is the acknowledgement that effective social care revolves around relationships. The Social Care Workers Registration Board (SCWRB) defines social care as a relationship-based practice through which a planned and purposeful provision of care, protection, psychosocial support and advocacy is provided (SCWRB 2017). Despite this recognition, reiterated in social care policies and literature, a certain amount of ambiguity exists on how relationships are practised. It is my view that the dynamics of social care relationship, ***the actual doing of relationships***, warrants more visibility and discussion in both academic literature and social care policies. Although consideration must be given to variables such as gender, sexuality, culture and class that shape the complex dynamic of the social care relationship, the argument put forward in this chapter centres on the importance of locating our critical understanding of this proficiency in the current social care practice environment.

The model of the dynamics of relationship put forward in this chapter endeavours to capture some of the visible and invisible individual and structural dynamics that impact on the relationship between the social care worker and service user. These include:

- ***The Practice Environment:*** Arguably the practice environment is an unexamined component in the dynamics of the social care relationship. It is the backdrop to our practice, the organisation culture, which includes such things as '*attitudes and beliefs, patterns of relationships, traditions, the psychosocial context in which work is done and how people collaborate in doing it*' (Menzies-Lyth 1990: 466-7). The practice environment is also shaped by legislative, social and economic influences, unconscious assumptions, attitudes and beliefs about the work task – the unspoken shared attitudes, the unacknowledged anxieties, conflicts, as well as the work atmosphere. The practice environment also includes the dynamics of multi-disciplinary and inter-agency practice, all shaping the dynamics of the social care relationship.
- ***Doing the Relationship:*** An understanding of the dynamics of transference and counter-transference in the social care relationship provides us with insight into service users and our own inner world. Using our first voice (Weick 2000) we can highlight the complexities of 'doing the relationship', advocating a move to work in solidarity, moving away from a 'them and us' attitude.

- ***Supervision and Support:*** Supportive supervision practice allows us to reflect, self-analyse and respond to visible and invisible dynamics operating within the relationship as well as the complexities of the wider practice environment. Social care workers' experience of support and being supervised is crucial to them being able to develop the capacity to recognise transference and counter-transference, individual and structural dynamics and the complexities of professional relationships.



The chapter begins with a discussion on the backdrop to all relationships; the practice environment.

Practice Environment

Against a backdrop of rapid societal and organisational change in the social care practice landscape, engaging in relationship-based practice presents challenges. The central argument based on research on relationship-based practice (Brown 2016) is that a culture of fear and risk underpins the practice environment, shaping knowledge, permeating the everyday norms and practices within the sector; and manifesting itself in the ways that relationships between social care workers and service users are constructed, experienced and lived out.

Discourses around 'risk' and a 'risk society' create the context in which fear emerges. Emotional responses to 'risk' and living in a 'risk society', it is argued, are designed to minimise and negate risks (perceived or real). Douglas notes that risk provides a powerful '*forensic resource [...] a language with which to hold persons accountable*' (Douglas 1999: 22), making it difficult for workers to work in risk-enabling ways due to fear of blame or liability (Ellis 2014) and in turn being held personally accountable (Furedi 2006; Gharabaghi & Phelan 2011). This can result in social care workers feeling fear in their daily experiences of practice (Smith 2009; Howard 2012). These fears can contribute to a climate where '*not taking risks is positively advocated*' (Furedi 2006: 71) and where risk-taking becomes viewed as irresponsible behaviour and accidents the result of risk management failings. Consequently, risk is understood as a form of governmentality that undermines traditional practices of relationship-building (Furedi 2006).

Arguably social care workers' responses to risk can be underpinned by anxiety and fear. The consequence of these fears and anxiety are manifested in relationships between social care workers and service users, where the main focus is often primarily on self-protection as the prelude for any professional interactions. In other words, staff and organisations have come to take their own safety as the starting point for 'professional' interactions (Steckley & Smith 2011: 84). It could be argued that this orientation has shifted relationship-based practice into a subsidiary of safe practice. In the context of daily professional practice where the relational aspects of the child-adult relationship, for example touch (Soldevila *et al*. 2013), have become the subject of regulation, constraint or have resulted in worker avoidance for fear of an allegation or complaint regarding improper, inappropriate and/or over-familiar contact. Steckley (2012) refers to these as the 'damaging cultures of "no touch"'.

There has, and continues to be, much commentary in the literature on the impact of these regulatory and prescriptive procedures on professionals' practice and the associated high levels of anxiety (Littlechild 2008; Brown 2016). Although the need to protect service users through improved regulation and inspection is viewed as a positive development, my research found that social care workers ability to develop and maintain relationships was constrained by bureaucratic requirements and the regulation of the relational space between workers and service users. Similar to recent criticisms in the literature (Smith 2009; Munro 2011; Howard 2012) reveal that regulatory responses were often in conflict with social care workers' professional values and views on relational engagement. In some sectors of social care practice relationships are now conceptualised in a way that is for utilitarian purposes of compliance (Murphy *et al.* 2013). This is where we can see the dynamics of the relationship between the social care worker and service user. In a national consultation with young people in care, 'Listen to Our Voices', one participant noted, '*after the social care worker played a role in me being arrested, it was difficult to understand the relationship, as the next day they would be nice to me*' (McEvoy & Smith 2011: 18).

Maintaining relational engagement while following procedure-led practice can frequently undermine and impact on established relationships of trust; in fact, procedure-led responses have often reinforced and contributed to the escalation of challenging behaviour. The focus on managing behaviour primarily through procedure-led responses with no space for professional discretion and professional judgement can hinder the development of positive relationships. Despite an increased awareness of the need for organisations to create a relational-oriented culture, criticism continues to be levelled at adherence to a bureaucratic culture with regularised systems taking precedent over relational-oriented practice.

Multi-disciplinary/Inter-agency Practice

The challenge and complexities of multi-disciplinary and inter-agency practice have been consistently highlighted in the literature (Ferguson & Kenny 1995; Horwath & Bishop 2001; McWilliams 2006; Duggan & Corrigan 2009). The complexities of multi-disciplinary practice are evident in the daily experiences of workers, impacting on the dynamics of the relationship between social care worker and service user. In addition, the relational dimensions of social care can often place heavy burdens on service users, who are required to navigate relationships with a number of professionals. Navigating these relationships can be challenging, particularly when they experience poor inter-agency and multi-disciplinary practice. An example of poor inter-agency communication was noted in Buckley's (2009) research: service users stated how they had to give the same information over and over again to different professionals whom they considered should be more connected to one another (Buckley 2009). Arguably these kinds of experiences add further to the challenges service users are endeavouring to deal with.

Organisation structures in social care reflect an established hierarchy which is reflected in the way decisions are made. A number of social care workers feel their role and contribution are judged as lower in the hierarchy, and not sufficiently recognised and acknowledged in inter-agency working relationships (Brown 2016). The lack of shared responsibility is exacerbated by what Buckley (2003) calls the 'exaggeration of hierarchy'. This refers to the privileged position afforded to the views of higher professionals such as psychologists over those of the workers who are in closest contact with children and families. The notion of the 'closer to the child, the further from the decision' was reiterated in the Brown (2016) study. Despite the regulations and official ideology emphasising the importance of professionals working together in meeting the needs service users, for some workers it is experienced as a discourse rather than a practice (Houte *et al*. 2013). It is argued that effective collaboration will only be achieved if efforts are made to articulate challenges, both long-standing and current. It is further argued that these challenges, if left unspoken, will continue to manifest in professional relationships and in the dynamics of relationship between service user and social care worker.

The poor quality of multi-disciplinary practice, or its failure to occur at all, has been identified in every inquiry report to date. Buckley (2009) highlighted that failings within multi-disciplinary practice reflect the dynamics between professionals and the tensions between and within agencies. She posits that these issues will not be solved with regulatory measures; they need to be addressed by supervision and capacity building within a supportive framework (Buckley 2009). With the reconfiguration of services, efforts have been made to promote multi-disciplinary practice with the establishment of collaborative structures and systems. However, as advised by Horwath and Morrison (2007), collaborative structures do not necessarily guarantee the realisation of collaborative activity; it is the informal relationships that are pivotal in inter-agency work, but they need to be supported by more formal linkages and acknowledged as an essential component of inter-agency practice.

Transference and Counter-transference

> *'From a relationship-based perspective identifying conscious and unconscious constraints on practice responses is vital'* (Ruch 2009: 358).

'In therapeutic circles it usually refers to feelings in relation to past relationships that are transferred to a therapist' or, in this case, the social care worker (McCluskey & O'Toole 2020: 38).

This proficiency centres on the dynamics of relationship practice, focusing specifically on transference and counter-transference, terms associated with a psychodynamic perspective (McCluskey & O'Toole 2020). Transference and counter-transference are based on the tenet that an unconscious previous experience can influence the dynamics of the relationship process. Transference is a dynamic that happens in the relationship between service user and social care worker. Transference is when the service user unconsciously transfers feelings from another person/experience onto the social care worker. It is considered a form of projection, e.g., a previous negative experience of male relationship being transferred by a service user into the relationship with their male social care worker. Ruch (2012: 63) states that transference occurs when someone treats another person as if they were a significant figure from their past and behaves towards them as if they were that other person.

Counter-transference

'[U]sually refers to the therapist's ability to note and make sense of emotions he or she is experiencing in the presence of the client and to consider these as important, if unconscious, communication from the client' (McCluskey & O'Toole 2020: 38).

Counter-transference is described as the inner emotional reactions of a social care worker to the service user's transference. It can be a conscious or unconscious emotional reaction experienced by the social care worker. Counter-transference also refers to the social care worker independently transferring their own feelings to the service user. In our practice, we may encounter service users who have gone through similar experiences to us, for example the loss of a parent at young age. This can evoke emotional reactions in the social care worker, leading to counter-transference in practice.

The social care worker's counter-transference reaction may manifest in certain types of behaviour, e.g., feelings of sadness on days you are engaging with the service user, becoming tearful when you thinking about the service user's situation. The challenge for the social care worker is being effectively engaged with the service user in the moment, while also being sufficiently detached to identify what is happening in the transference or counter-transference as it emerges. This dynamic can often be difficult to understand and manage and social care workers can, in turn, find themselves reacting unconsciously.

In teaching students about transference and counter-transference, van Breda and Feller (2014: 470-1) utilised Sedgwick's (2013: 108) idea of 'cup hooks' through the following analogy.

THE CUP HOOKS – EXPLAINING TRANSFERENCE AND COUNTER-TRANSFERENCE
• Imagine that you have cup hooks sticking out of your body. Lots of cup hooks. Each hook is something about who you are and what you have experienced. There are hooks for your gender, race, weight, education and town of origin. There are hooks for your experience of growing up as a lonely child, there are hooks for your views about your body image.
• As you practise the service user is constantly throwing out little lassoes – strings with a loop at the end. The service user throws them your way the whole time, unconsciously of course, their string is going to hook onto one of your hooks. When that happens, the service user ropes you in, establishing a connection, a relationship.
• Not only you, but the service user has hooks for all their characteristics and experiences. And you yourself are also throwing out strings and making connections. The relationship involves these unconscious connections, tapping into service users' vulnerabilities and strengths. This is termed transference and counter-transference.

First Voice

Consider this Quote:

'Any developed theory of what counts for good practice should at least start with the hard-earned wisdom of its practitioners' (Sinclair & Gibbs 1998: 115).

A key question is how we get beyond this to a position where the dynamics of the social care relationship are explored and understood at both micro and macro level. While the relationship has been broadly discussed in the literature, there is a need for further discussion on the dynamics of relationships; in a knowledge vacuum, relationships are considered a 'largely empty word' (Smith *et al*. 2013: 12). Arguably, because relationships do not sit neatly in an evidence-based intervention, and neither can they be scientifically measured, this could explain the lack of critical analysis on the conceptualisation and dynamics and reflect a view that relationships between workers and service users evolve organically. In conceptual and policy terms, positive relationships are recognised and valued; however, a current critical understanding is largely absent. Weick's (2000) advice to social workers to avoid using their dominant professional voice and instead use their first voice, is relevant to the social care relationship. Within the social care field, excellent practice is not hard to find (Flynn 2020), but we need to make this visible. We need to continue to work in solidarity with service users, and distance ourselves from the 'them and us' attitude.

Furthermore, qualities and skills that make up relationship-based practice often remain invisible for fear of being negatively labelled as 'over involved' or 'unprofessional'. It is this lack of fundamental recognition for all the elements that make up relationship-based practice (that is, use of personality in acts of individual and spontaneous kindness, humour; use of body through touching, hugging, comforting; and use of self as a social subject in the exercise of individual judgement, for example) that needs to be challenged and changed. In using our 'first voice', as workers we may move away from feelings of alienation and gain visibility and recognition in the wider context of practice. (Lack of visibility was particularly noticeable during COVID-19, with little acknowledgment in the media regarding the social care profession working at the coalface during the pandemic).

Part of the responsibility of social care workers in asserting their voice is not only to assert their experiences and views regarding best practice, but also to use their voice to challenge and change society's perceptions of service users. We need to highlight that many of the challenges service users experience have origins in inadequate systems of support, e.g. education, housing. Inequality can manifest itself in different forms and impact a myriad of fields, such as employment, housing discrimination, education. For many service users whose trust has been abused in the past, either by a neglectful family or by a system that has failed to take their needs and wishes into account, 'relationships are not easily constructed' (Millham *et al*. 1986: 118). Past experiences of relationships often influence how we engage in current relationships (Cashmore 2002). These factors shape and influence the dynamics of the social care relationship.

There is one serious omission in the writings and reports on service users, despite the adversities they have experienced in their lives; they have an inner strength and sense of humour, which needs to be recognised in the literature. Professionals need to draw attention to their wisdom and resilience and policy makers need to learn from their lived experiences. Our recent Olympian champion Kellie Harrington's brother encapsulated this when he stated that the area his family live in, although considered disadvantaged, is 'one of the richest areas in the country because it is rich in support, camaraderie and community values'.

Going forward, it would be helpful if changes in the educational landscape could be effected to bring to the forefront, in training and teaching, themes such as 'use of self' and reflective practice, dynamics of transference and counter-transference within the wider ambit of relationship-based practice. A particular practical example of this, and following on from Anglin's work (2015) on training, is to make workers aware of their own pain-based anxieties in order to be responsive rather than reactive. This will require course delivery that centres on tutorials and individual contact with the aim of increasing the level and quality of contact. Another way of enhancing training is through multi-disciplinary training, particularly on accredited courses. The training would require a strong focus on the '*emotional dimensions of practice*' (Munro 2011: 91), which is probably best achieved by a combination of tutorial input and professional practice input.

TASK 1

Read the *Listen to Our Voices* report (McEvoy & Smith 2011), available as a free PDF from https://www.lenus.ie/handle/10147/139489?show=full.

Q. Consider how you would address young people's concerns with regard to relationship-based practice.

TASK 2

Read the Crisis, Concern and Complacency Report (Keogh & Byrne 2017), available as a free PDF from https://www.researchgate.net/publication/312211150_Crisis_Concern_and_Complacency_A_Report_on_the_Extent_Impact_and_Management_of_Workplace_Violence_experienced_by_Social_Care_Workers

Q. Reflect on the changes that have occurred as a result of the findings in the report.

TASK 3

Read Buckley *et al.*, *Service Users' Perceptions of the Irish Child Protection System*: https://www.researchgate.net/publication/284722126_Service_User's_Perceptions_of_the_Irish_Child_Protection_System

Q. In small groups, discuss how the service user's views and experiences impact on dynamics between social care worker and service user.

Support/Supervision

'*The more we can create a space inside ourselves that has capacity to relate to where service users find themselves, the more effective we will be*' (Simmonds 2018: 235).

Working in systems governed by processes that are procedural, bureaucratic and have the tendency to enforcing regulations, emotional support for staff is identified as a prerequisite for the positive development of relationships (Trevithick 2014). The importance of social care workers being afforded reflective spaces and opportunities for reflective practice (Ruch 2007), in a supportive practice environment, cannot be over-emphasised. However, inadequate levels of support and supervision for front-line workers has been highlighted in every inquiry report to date. Within the context of supervision, in recent research by Keogh and Byrne (2016), social care workers articulated feeling

a lack of emotional support, mainly from the wider organisation, with 'supervision … never or only sometimes provided by management for the majority of social care workers' (2016: 75). This is particularly concerning because regular professional supervision for social care workers is a statutory standard inspected and monitored by the relevant authorities.

A theme emerging in the literature is that supervision appears to be become skewed towards policy and procedural imperatives, rather than towards reflection and professional development (Jones & Gallop 2003; Ruch 2007). Policies and guidelines clearly articulate the importance of regular supervision; however, there is a tendency in the literature to focus primarily on providing regular formal supervision. The relationship between workers' engagement at supervision in terms of their feelings of value is given insufficient attention. This can mean that unexplored fears and anxiety that can manifest in the day-to-day practice of relationships remain unexplored, thereby affecting the day-to-day effectiveness of relationship-based practice. It is argued that the emotional climate (Ward 2010) needs considerable attention to enable workers to process feelings (Sharpe 2008), understand the dynamics of transference and counter-transference and embrace the emotional elements of practice (Trevithick 2014). We need to create a practice environment that is characterised by respect, safety, trust and openness, which we can mirror in our relationship with service users.

Reflections on Transference and Counter-transference in Practice
• Understanding how transference and counter-transference is manifested in the relationship can help the social care worker and service user engage appropriately with these dynamics.
• Transference and counter-transference, when understood, are windows to our inner worlds. It is important to support the service user in identifying when transference is happening and understand where it is coming from.
• Having shared experiences with a client may enhance one's ability to empathise with a client, for example if you have shared experience of losing a parent at a young age.
• Transferential responses need to be understood in their cultural context.
• There are many other ways to categorise and conceptualise transference.
• Transference and counter-transference can emerge in any relationship and may happen at any time in the relationship, from beginning to disengagement stage.

Conclusion

As a social care worker one of the biggest challenges you will face is being able to simultaneously focus in professional encounters on what is happening for the service user and what is happening to you.

The pivotal argument in this chapter centres on recognising and addressing the contextual factors at the organisational levels (practice environment) that impact on the dynamics of the relationship between social care worker and service user. Social care's remarkable strength as a profession is our persistence and commitment to relationships in practice environments that can be challenging and complex. We need now to create openings and opportunities to ensure that we are no longer at the periphery and contribute to a practice-based body of knowledge on the dynamics of the social care relationship.

Tips for Practice Educators

- Placement experience is usually students' first opportunity to experience relationships in practice. Students need to be encouraged to use their reflective diaries to record their feelings and views on relationships in their practice placement.
- Practice educators can observe the student engagement in relationships with service users and the staff team and use these observations as discussion points in supervision.
- Practice educators have a pivotal role in supporting the student by creating a safe space in supervision for the student to explore their vulnerabilities and supporting them in identifying tools to recognise and manage transference and counter-transference patterns.
- It is important to highlight that the student's supervisory experience can be a prototype of how relationships with service users should work.
- Fenton's (2015) SOS model of relationship-based self-care incorporates three forms of relationship that the students can explore and use as an agenda for supervision sessions. These are: relationship with Self; relationship with Others; relationship with the System.
- Practice educators can provide direction with regard to self-care practices students can adopt.
- How a social care worker can build a relationship with someone who does not one to engage is an area that warrants discussion. Involuntary service users and defensive relationships are a part of social care day to day practice. Support the student in acknowledging and understanding the presence of difficult emotions in the dynamics of hostile relationships.

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Chapter 71 – Padraig Ruane

Domain 5 Standard of Proficiency 10

Be able to identify, interpret, record and respond appropriately to patterns of behaviours displayed by service users in a variety of settings

KEY TERMS

Patterns of behaviour
Identify
Interpret
Record
Respond appropriately

Social care is … bringing it back to the person, remembering that they have the same rights as you and me. The person has dreams, desire and emotions like any human. In social care setting people are given many labels, e.g., a person with … intellectual disability, Down syndrome, autism, mental health problems. These diagnoses are often necessary to ensure the person gets the support they require, but we must not forget that above all they are people. Social care is protecting the humanity of the people we work with.

Patterns of Behaviour

In the area of social care, in particular disability services, the term 'behaviour' is often associated with words such as 'challenging', 'concerning' and 'responsive'. Social care degrees offered by third-level institutions tend to have a module on 'challenging behaviour'. Multi-disciplinary teams often include a behavioural support specialist. Organisations such as Studio 3 and the Callan Institute provide training on managing challenging behaviour, multi-element behaviour support or positive behaviour supports. If you look at the policy section on the National Federation of Voluntary Bodies website you will come across a number of policies and guidance documents on the topic of behaviour, including supporting people with challenging behaviour, guidelines on management of behaviour that challenges. The area of challenging behaviour is heavily researched, but it is worth noting that absent from a lot of the research is the voice of the person and their contributions in term of what they believe works and does not work. As social care workers, supporting people who have behaviours that challenge is a major part of our role. This chapter will focus on the intellectual disability setting.

TASK 1

When you read the phrase 'patterns of behaviour', what comes to mind? Is it negative or positive?

Historical Context

The literature offers numerous definitions of what 'challenging behaviour' means. A widely used definition by Emerson *et al.* (2011) describes challenging behaviour as:

> *'Culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities.'*

In recent years, there has been a move away from using the term 'challenging behaviour'. Jeffrey Chan and colleagues, in their article 'Is it time to drop the term "challenging behaviour"?', argue that the term 'is associated with a crisis response approach to service delivery in which behaviours are assumed to be inherent in the people who exhibit them.' The most common alternatives are: behaviours of concern; responsive behaviours; behaviours that challenge. It is important to note that despite the move away from the term 'challenging behaviour', Emerson's definition is still widely accepted and can also be used for the alternative terms. The purpose of moving away from the term 'challenging behaviour' is to show that it is not inherent in the person or a diagnosis.

Challenging behaviour is not a diagnosis

It is important to note that 'challenging behaviour' is not a disorder that a person can be diagnosed with. When working in the area of social care you may hear phrases such as 'her challenging behaviour' or someone being described as 'having challenging behaviour'. This use of the pronouns and verbs implies that the issue is in the person. It is important to recognise that the behaviour is rather the result of an interaction between the person and their environment.

Research has shown that there is higher incidence of 'behaviours that challenge' in people who communicate differently, have diagnosis of severe to profound intellectual disability, autism, mental health issues, visual impairment and hearing difficulties. This is often as a result of the setting or environment not being adapted to meet the person needs.

Behaviour as Communication

Behaviours that challenge should be considered a means of communication. Read the following example:

Case Study 1

David is young man with Down syndrome and he communicates differently. As part of his weekly schedule he goes for a walk in the local park on Tuesdays. Staff have noticed recently that David is reluctant to go on the walks. He has refused to put on his walking shoes. On occasion he become upset and has thrown his shoes, nearly hitting staff and fellow residents.

Take a moment to think about what David could be communicating with his behaviour.

Is he in pain? He could be communicating pain or discomfort. Are the walking shoes hurting him? Do they fit him properly?

Is the activity the problem? Is he communicating that he doesn't want to go on the walk? Perhaps he doesn't enjoy it? Perhaps the weather is getting colder?

Are the people he is going with a problem? Is he communicating that he doesn't want to go with the staff or residents? Does he refuse to put on his shoes every week or only with certain staff?

Is he communicating his frustration at a lack of choice? Does David want to go on the walk? Often exercise is recommended for people by their GP and a schedule is developed without the person being involved. Is there something else he would rather do?

Is David aware of the schedule? Does he know that he is due to go for a walk? Oftentimes someone's weekly schedule is placed in the personal file. Would David benefit from having a visual timetable? Do certain staff have a better way of communicating with David in advance?

As you can see, a simple behaviour such as a person refusing to put on his shoes can be communicating a number of things. It takes keen observation skills and high level of awareness from the social care worker to identify and interpret the behaviours. This brings me on to the fact that behaviour that challenges can be subjective.

It is important to note that when a person communicates differently it is often the case that decisions are made on their behalf without proper involvement of the person. There can be a belief that a person would not understand and cannot make decisions. In line with the principles of the Assisted Decision-Making Act 2015, there should be the presumption of capacity. Information should be provided to the person in an accessible way and they should be supported to communicate their will and preference using any communication method required.

Staff Interpretation

Take the case study example. Imagine that there are two social care workers supporting David that day. They both witness the incident. Each social care worker may come away with different interpretations. Social care worker A may see the behaviour as a refusal to engage in the walk and that David has responded inappropriately. Worker A may suggest developing a support plan to help David engage in the activity. Social care worker B may feel that David's refusal to put on his shoes is a method of communication, and they may suggest developing a support plan to explore what is being communicated.

If the shoes were causing David pain, refusing to put them on would be an appropriate response and would show a level of insight. This behaviour is actually quite adaptive and functional from David's perspective. The reason the behaviour is challenging is because the service is not adapting to his needs. The person may require communication supports, e.g., Lámh, PECS or communication devices. The service may need to review the staff roster, schedules, etc.

When we talk about behaviours that challenge it is important to ask, 'Who does the behaviour challenge?' Take the following example:

Case Study 2

Carol has moderate disability with mobility issues. She lives at home with her parents. Carol frequently wakes up during the night and will sometimes go for a walk around the house. Her mother is concerned that she is at risk of falling down the stairs and injuring herself. Carol waking up early in the morning is challenging for her parents as they have to get up with her. There is no doubt that the consequences of this behaviour are challenging to the parents, but with the correct supports the behaviour would not be deemed challenging. If Carol was living in a bungalow with night staff, her waking up during the night would not be an issue.

Context

The context and setting where a behaviour occurs can influence whether or not it is deemed challenging (Emerson and Einfeld 2011).

TASK 2

Think about the following situations. Think about what behaviours are acceptable and unacceptable in each.

- Visiting a library
- Watching football match
- Attending a music concert
- Attending a religious service

Notice that behaviour that is acceptable in one setting, such as shouting and cheering at a football match, is unacceptable in another, such as visiting a library. Think about the music concert: depending on the genre of music and venue there may be major differences in what is acceptable. The crowd behaviour at an open-air rock concert may be very different from a seated audience at an orchestral recital. The behaviour appropriate at a religion service will depend on the particular religion and culture.

Having an understanding of patterns of behaviour is important in the area of social care. The role of the social care worker is to identify, interpret, record and respond appropriately to the person's behaviours. That is what we will discuss next.

Identify

Identifying the Behaviour

The first thing you must do is identify the specific behaviour or behaviours. What is the person doing? Rather than simply saying the person is displaying 'behaviours that challenge', identify the actions. Are they shouting, scratching their arm, pushing a fellow resident?

As social care workers we must be aware that people can become labelled as displaying 'behaviours that challenge'. This can result in an attitude among staff of 'That's just how he behaves', or 'That's just what she does.' This can lead to staff becoming immune to behaviour, for example 'Julie always shouts, it doesn't mean anything', or interpreting all behaviours as challenging.

It is important to take time to identify the behaviour and not jump straight into interpreting every behaviour as 'behaviours that challenge'.

Identifying the Setting Event

A setting event is anything that increases the person's anxiety or decreases their ability to tolerate a situation. The setting event can be something that happened in the past or in the build-up to the behaviour, for example not getting enough sleep the night before, an incident in day service, the person feeling sick. A setting event can be a one-off event such as a cancelled visit with family or a build-up of events over time that can lead to an increase in anxiety. Setting events happen to everybody, whether or not they have an intellectual disability. The social care worker plays an important role in identifying the setting events. Through building a relationship with the person, the social care worker will develop a deep understanding of them. The social care worker will be able to identify setting events that the person may not be aware of. This is particularly important where a person communicates differently.

Identifying the Trigger

A trigger is an event that occurred immediately before the behaviour that 'caused' it. Being aware of potential triggers can be the first step in developing a support plan to reduce behaviour. Some common examples of triggers are:

- Being asked to do something or being told not to do something
- A noisy or busy environment
- A particular individual or activity
- Being bored.

The knowledge and insight the social care worker has of the person will allow them to identify triggers.

TASK 3

Imagine you have just started a new job in a residential service for people with intellectual disability. During your induction you are told that one of the residents, James, 'has challenging behaviour' without any details about what the behaviour is, what the setting event or triggers are. Think about how ill-prepared you would be to support James. In situations like this it is important to ask for further information: What are the specific behaviours, setting event and triggers?

Interpret

When behaviours that challenge happen it may seem like there is no obvious reason, but there always is a reason and the challenge for services is to work out what the purpose of the behaviour is. The Challenging Behaviour Foundation has developed the following table, which outlines four areas to consider.

Social Attention: We have all heard the saying, 'It's just attention-seeking behaviour.' It isn't bad to want attention from others. However, for a variety of reasons (e.g., limited communication skills, boredom, or an inability to occupy themselves), some people may learn that behaving in a particular way is a reliable way of attracting others' attention, even if it is negative attention.
Tangibles: Here it is the desire for certain things (e.g., food, drink, objects or activities) which is providing the motivation for the behaviour. Again, it isn't bad to want these things. If you are hungry, it makes sense to try and get something to eat. If you see something in the shop that you like, it makes sense to try and get someone to buy it for you. However, it becomes a problem when the person learns to act inappropriately to get these things.
Escape: While some people like attention, others would prefer to be left alone. Rather than behave in a particular way to get people's attention, some people will behave in a way that helps them to avoid/escape situations or activities that they don't like, or don't find that rewarding.
Sensory: Sometimes behaviour is internally rewarding, or self-reinforcing, i.e., what is happening around the person (externally) is not as important as what is happening inside the person

Source: Challenging Behaviour Foundation Information Sheet (www.challengingbehaviour.org.uk).

Record

Recording should be done in line with policy and best practice guidelines. (See Domain 3 Standard of Proficiency 2 for further information.) When recording an incident it is important to remember the following: be factual; describe specific behaviour (e.g., 'Colm bit his arm' rather than 'Colm engaged in challenging behaviour'); and note any setting events and triggers. It may take a long time to understand the reason behind a behaviour. Having accurate reports is vital in helping the service get a full picture of the behaviour. As a social care worker you may feel that it is a reflection of your skill as a professional if a person engages in behaviours that challenge when you are working with them. This may make you reluctant to report incidents. But it is important that you report all incidents; there are often multiple reasons for a person's behaviour, not solely their interaction with staff. If there is an area that you need to improve on, your manager and service should provide you with supervision, coaching and training to develop skills in this area.

Respond

A common method to support people with behaviours that challenge is by using positive behaviour support. It is an evidence-based approach with the primary aim of increasing the person's quality of life and the secondary benefit of decreasing the regularity and severity of their behaviours that challenge.

What is Positive Behaviour Support?

The key components of positive behaviour support are:

Person- centred	**Inclusion of relevant stakeholders**	**Assessment-based**
Support plans	**Reduction in restrictive practice**	**Skills building**
Staff development	**Environment change**	**Systems change**

What does a Behaviour Support Plan Look Like?

Behaviour support plans include the following three areas:

1. **Primary prevention:** This means putting in place supports to meet the person's unmet needs. Examples of such supports are making changes to the person's environment, improving communication, enhancing active engagement in meaningful activities.
2. **Responding to early signs of behaviour:** This part of the behaviour support plan aims to find out what the person is communicating through their behaviour and provides a prompt for staff to respond effectively to the early behaviour before it escalates.
3. **Reactive strategies:** How to effectively respond to the behaviour when it happens. The plan aims to ensure:
   - the safety of the person and others around them
   - that the least restrictive practices are used
   - that the person develops new skills and re-engages in positive behaviour and interactions as quickly as possible.

Social Care Worker Input into Multi-disciplinary Teams

It is common for behaviour support plans to be developed by a multi-disciplinary team (MDT). The social care worker has an important role here as they are the professional who knows the person best and witnesses first-hand the person's behaviours. The quality of the behavioural support plans developed by the MDT relies on the information they receive from social care workers working directly with person.

The success of the positive behaviour support approach is reliant on the skills and commitment of the social care workers implementing the plan. When it comes to reviewing the plan the social care worker plays an important role in providing feedback to the MDT team. The social care worker plans an important role in ensuring that the person is included in developing the plans as much as possible.

Tips for Practice Educators

- Move away from the term 'challenging behaviours' to 'behaviours that challenge', 'behaviours of concern', 'responsive behaviours'.
- The importance of behaviour as communication.
- Challenging behaviour is not a diagnosis.
- Importance of accurate recording. Having accurate reports is vital in helping the service get a full picture of the behaviour and developing supports.
- The important role social care workers play in MDTs as they work directly with the person, implement the plan and can give feedback on its effectiveness.
- There should be a focus on what students may see or experience. There should be an acknowledgement that they may be fearful initially, but seeing the behaviour as communication will help, and support will be provided.
- Supervision and promoting reflective practice is important.

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Chapter 72 – Denise Lyons

Domain 5 Standard of Proficiency 11

Be able to analyse activity and adapt environments to enhance participation and engagement in meaningful life experiences and positively influence the health, well-being and function of individuals, families, groups and communities in their everyday activities, roles and lives.

KEY TERMS

Heart, head and hands

Meaningful life experiences

Everyday activities

Participation and engagement

Environments and contexts of care

Social care is … a relationship, a psychological space between people, where they can grow, have their needs met, can learn to trust, feel accepted and heard. It is a privilege to work with people, especially at a time in a person's life when they are defined by society as 'vulnerable'. It is our job to bring kindness and our humanity to our interactions with others, without judgement or bias. Social care is very challenging because of the daily demands to be both personal and professional, to reflect and be present and to bring love and kindness to the people we have the pleasure to encounter in our working lives.

Social care practice has developed from individual service provision to organisations providing care and support for families, groups and communities. This standard of proficiency highlights the core of social care practice; that workers can focus their practice and adapt the environment to promote a person's participation in meaningful moments and experiences. Creating environments that enhance participation and engagement requires us to adopt a holistic approach, which I have framed in a model for social care work entitled 'Heart, Head and Hands'. This model is based on the findings from my PhD research (Lyons 2017) illustrated below, which uses Johann Heinrich Pestalozzi's famous trinity of 'head, heart and hands' (Brühlmeier 2010) and incorporates ideas of contemporary theorists from practice in Ireland, Scotland and Canada (Doyle & Lalor 2009, 2013; Smith 2009, 2012; Garfat 2008; Garfat & Fulcher 2012; Digney & Smart 2014). The 'heart, head and hands' approach to social care practice presents the heart first, emphasising that all practice is contained within the relationship between the worker and the other (Lyons 2017). The 'heart' of the model outlines the values and attitudes needed to focus your practice on enhancing the service user's participation and engagement in meaningful life experiences. The 'head' denotes all the knowledge underpinning this proficiency, including the key themes of this chapter, meaningful life experiences, everyday activities, participation and engagement, and contexts of care. 'Hands' relates to the practical activities and interventions that, when performed with care and respect, can 'positively influence the health, well-being and function of individuals, families, groups and communities in their everyday activities, roles and lives' (SCWRB 2017: 9).

Heart, Head and Hands – These are the main themes that emerged from my PhD research (Lyons 2017) on what social care workers 'do with others' in a variety of Irish social care settings.

HEART

- Be In-tune with emotions
- It hurts, but become emotionally involved
- Care through touch
- Understand how to love
- Take care of yourself.

HEAD

- Learning through the relationship
- Using common sense
- Being creative and questioning
- Being cognitively engaged
- Being self-aware and using knowledge in practice

HANDS

- Social care is practical, know life skills
- Learn how to do with others
- Hanging out is doing
- All tasks' including cleaning and toileting are care
- Take time to be with others

TASK 1

Read Chapter 6 ('Doing Small Things with Great Kindness', by John Digney and Max Smart) in Howard and Lyons' *Social Care: Learning from Practice*). Compare Figure 6.1 on page 64 of the book with the themes in the illustration above.

The 'hands', or doing stage, reflects how care is viewed as a verb, an action word, and what we do with others. These hands-on activities include day-to-day tasks, 'direct care tasks' (Fulcher & Ainsworth 2012), rituals of everyday life (Smith *et al.* 2013), and everything we do with people. They all involve one person engaging with another while they are doing things together and being with each other. We engage in activities, provide care and meet needs through the relationship (McHugh & Meenan 2009, 2013; Burton 2015). The relationship between a worker and service user is meaningful (Digney & Smart 2014), and trusting (Ruch *et al.* 2010; Howard & Lyons 2014). The relationship is the 'core' of practice that enhances the services user's daily life experiences, supporting their increased participation in the community and enhanced health and wellbeing (Kennefick 2006; Lyons 2009). We cannot support a service user to engage in meaningful experiences and purposeful activities without first getting to know them, through being in a relationship. Garfat theorised this experience of being in a relationship with others through the terms 'hanging out' (spending time doing 'normal' things together), 'hanging in' and 'counselling on the go' (Garfat & Fulcher 2012).

01

Hanging out

Hanging out is an important concept because it provides a language for the purposeful use of sharing time together for social care practice 'Hanging in' reflects the commitment to care (Gompf 2003) that is the responsibility of every social care worker, which takes time and patience (Garfat & Fulcher 2012; Digney & Smart 2014).

02

Counseling on the go

'Counseling on the go' is based on the potential of service users to hare painful memories and experience with their key-workers, while they spend time together (Mann-Feder 2011).

03

Hanging In

Hanging in' reflects the commitment to care that is the responsibility of every social care worker, which takes time and patience (Digney & Smart 2014).

Through hanging in, hanging out and counselling on the go, social care workers learn the likes, dislikes and needs of the service user, in order to communicate, advocate and engage. Using the relationship in this way enables workers to act as a bridge between the service user, other professionals and the community, where social care workers can effectively advocate and communicate these needs. The relationship is what makes social care work distinctive; it is the most important learning space for practice. As discussed, engaging in activity with services users also includes daily tasks that can enhance their overall health and wellbeing, which includes physical and intimate care tasks.

Physical and Intimate Care Tasks for Health and Wellbeing

Social care workers engage in caring for the physical and intimate needs of others (Carnaby & Cambridge 2005), thus promoting and supporting the health and wellbeing of service users. This can include the manual handling tasks of lifting, using hoists, pushing wheelchairs, and moving furniture and aids. Many students find providing for the physical and intimate care needs of service users difficult, and this is viewed as one of the main deterrents to taking up a career in the disability sector. Personal care tasks include shaving, skin care or applying external medication, hair care, help with feeding, teeth care, undressing and dressing, applying makeup and deodorant, and prompting to go to the toilet or bathroom (Twigg 2000). Intimate care duties, by virtue of the title, are more personal and include dressing and undressing (underwear), helping someone use the toilet, changing soiled incontinence pads, bathing and showering, washing intimate body parts, menstrual care, administering enemas, and administering rectal medication (Carnaby & Cambridge 2006). When providing intimate care, it is essential that the space is adapted to ensure that a person's dignity is protected (Twigg 2000). In all care duties, the social care worker is trying to ensure that intimate experiences feel respectful and private and are performed with dignity. There may be opportunities to provide meaningful moments while brushing someone's hair or while patiently supporting an individual to select what they want to wear that day. As social care workers, we use daily events within our planned practice to enhance a person's involvement in experiences that are beneficial and meaningful to them.

TASK 2

Describe a recent experience that was meaningful for you in your life. Why was this experience important?

Meaningful Life Experiences

Meaningful Life Experiences

Supporting a person to have meaningful life expereiences, irrespective of their ability or current life situation, can be difficult. One way to approach this is through a holistic approach to your practice using your head, your heart and your hands.

Activities can provide opportunities to enhance the relationship and create meaningful moments within day-to-day shared life events. Having a meaningful experience is tied to having a sense of purpose, feeling productive and needed, having a satisfying social network, and a sense of belonging within close reciprocated relationships. We use the head when we are actively involved in the work of social care and facilitate meaning-making through mutual engagement and doing things together within the relationship. This is purposeful practice, based on an integration of the theories that underpin the work and experiences that inform and shape it. When we have a relationship with another person, we work from the heart, showing care and kindness, unconditional positive regard and empathy.

Everyday Activities

Getting to know a person enables you to learn about their likes and dislikes, what activities they enjoy, who they like to spend time with and what experiences are meaningful for them. Engaging in different activities can play a significant role in relationship development and the creation of meaningful moments. Social care is viewed as a hands-on role, where workers 'do' with others, though being together (Digney & Smart 2014).

Participation and Engagement

Like us, the people in our care are social beings who need to be provided with opportunities for fully participating and having a meaningful engagement with the world around them. One place to start is within the local community. Walking is an important activity for community engagement and social learning, where people can get to know others external to the service and find out what local services are available to them. Walking in the local neighbourhood is part of travel training for people with a disability, and in the HSE's *New Directions* report is viewed as one of the ways to achieve community engagement (HSE 2012). Getting out in the community emerged within the ethos of the normalisation of public and private spaces for the care of people, thus helping to recreate the space from the institution to the home. Social care workers do not always need to look beyond the service to promote participation and engagement; the service itself or 'context of care', with imagination and in collaboration with the service user, can also facilitate meaningful moments. The office can be viewed as a 'staff only' space, which can give the impression of spaces in a person's home that the service users are not permitted to enter. It is important to maintain a balance between the confidential storage of important information and the office documents and some space for the residents to sit and chat.

Adapting Environments – Creating a Home

Practice settings are the places and spaces that service users and workers inhabit which are flexible and adapted to meet diverse needs and practices. The question of 'where social care work happens' is complicated, as it includes the physical building or social care service and relevant social care spaces, which can include, but are not exclusive to, the kitchen, the office, the car, the coffee shop, the bathroom. Social care services are either a residential or day service, which is adapted to become an activity centre, a place for work and/or activity, treatment, care and love, and a person's home (Byrne 2016). Specific spaces are also purposefully used and adapted to enhance the service user's feeling of belonging and active participation.

TASK 3

This is the bedroom window sill in a residential home for adults. Who lives here? Why did you come to that conclusion?

(Drawing by Denise Lyons)

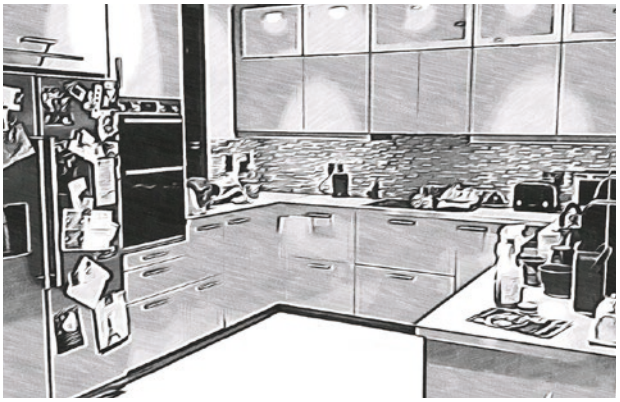
As well as being a practical base for the provision of care, spaces within the service can also evoke feelings of being welcome, or feeling at home. The service is the physical representation of how practice is influenced by policy, and valued by society.

Creating a Home: Social care workers often adapt a room or house as a space where meaningful life experiences happen on a daily basis in a place that is personalised, lived in and loved. Trying to recreate the experience of home in an unnatural setting is a difficult task, especially as there is limited scope within practice to discuss the meaning of home for both workers and service users. The idea of creating a homely space for people to live has become a national standard in all government publications on residential care since 2004: 'it should be as much like an ordinary family home as possible' (DoHC 2004: 31). Cooper (1974: 131) described 'home' as a personal space where we have control over the 'few intimates that we invite into this, our house', especially the people we live with. In reality, service users have limited control over the people invited to live, to visit, or work, in the space (HSE 2011). The appropriate placement of residents together in the one house is paramount, as it can be very destructive to a resident's placement if they do not get along with the other residents (Reynolds 2014). Having your own bedroom in the house can also increase the sense of home. The physical house is also viewed as an expression of self: 'we project something of ourselves onto its physical fabric' (Cooper 1974: 131). The expression of self is manifest in the material culture of the space including furniture, the way it is placed around the room, the selection of photographs and images hung on the walls (Woodward 2007). In residential services, service users may have limited involvement in the purchasing and placement of furniture and personal items in the house other than in their own bedroom.

(Drawing by Denise Lyons)

The desire to create a homely atmosphere is aided through rituals and social practices, for example making a cup of tea for people when they arrive at a day service or sharing a cup of coffee and a chat during the day in a residential house (Martin & Rogers 2004). Byrne (2016) discusses how staff used the cup of tea both as a way of engaging with the service users and also as a way of alleviating stress during the day; taking a break and having a cup of tea. This is most common for residential care staff who are not permitted to take a break away from the unit. Making tea is also a ritual between the staff members, where team meetings can evoke feelings of family and engagement, by starting with a cup of tea (Martin & Rogers 2004). Staff members can also feel more at home if the management creates a culture and atmosphere of respect where individual opinions are heard (Martin & Rogers 2004), in the negotiation of practice (Wenger 2010).

The kitchen, the heart of most social care services, can become a space for meaningful connections and experiences. This room plays a central role in ordinary family life but also in the lives of service users and social care workers. As well as the place designated for eating, the kitchen is also the room where people gather to perform everyday activities and do one-to-one work. In the home, families eat around the kitchen table, and this practice is viewed as part of normalisation in service provision. The kitchen is also a space where gender roles are practised, learned and adopted (Byrne 2016). It is important for social care workers to examine what practices exist within their service to ensure that everyone has an equal opportunity to engage, when possible and appropriate, in the preparation of food.



(Photograph by Denise Lyons)

The kitchen is a place where service users can express personal choice by having some input and participation in the menu and the food that is prepared there. The kitchen table is also a place for communication and relationship development, providing a focal point for a relaxed and non-threatening discussion. As well as the place designated for eating, the kitchen is also the room where people gather to perform activities, for example doing homework, playing board games and doing art.

The car: The car has become so necessary for social care work that many organisations list having a full driving licence as a prerequisite for employment (Ferguson 2009). The car can be an expression of care and humanity, through the act of collecting and bringing someone where they need to go (Miller 2001). As well as being used to bring people to their destination, for example to school or on an access visit, the car is also a space for purposeful relationship-based work. There are three factors that facilitate the role of the car for purposeful social care work.

(Drawing by Denise Lyons)

First, the reason for the journey (Ferguson 2009); second, being in the confined space of the car and moving between fixed spaces creates a pause in ordinary life; and finally, the arrangement of the car seats creates a physical space between the passengers, including the avoidance of direct eye-contact (Ferguson 2010).

Ross *et al.* (2009) explain how relationship-based social care work can become framed and bounded within the car. Sitting within the physical boundary of the car made young people feel safe, and this feeling encouraged them to share and have intimate 'car conversations' (Ferguson 2009). Ross *et al.* (2009: 612) described these 'car conservations' as free-flowing, 'offering a means through which young people could share past memories, associations, and future imaginings that the journey brought to mind'. The drawing above represents people engaged in a 'car conversation'. The worker is looking forward, and the lack of eye contact enables the young person to chat freely. The car can encourage the service user to leave the centre and get out into the community.

The community: Getting out and doing shared activities together outside is an important part of the shared experiences of social care work (Fulcher & Ainsworth 2012). Eating out in the community is an important social activity for people with an intellectual disability (Adolfsson *et al.* 2010). However, this activity may be limited based on multiple possible factors, for example: the unsuitability of the space for people with a disability; any behaviours of the service users that challenge; specific food allergies or requiring food liquidised or thickened (Adolfsson *et al.* 2010). Ross *et al.* (2009) mention the role of walking as an important activity for community engagement and social learning. Walking in the local neighbourhood is part of travel training for people with a disability, and is viewed a way of achieving community engagement (HSE 2012). Getting out in the community emerged within the ethos of the normalisation of public and private spaces for the care of people, from the institution to the home. Another way of getting out and about is through the use of the car, which, as we have seen, can also become a space for purposeful practice and meaningful experiences.

To understand social care is to acknowledge that the meaningful moments we achieve for individuals, groups and the community are shaped by the breadth, depth and complexity of practice. Of the many theoretical frameworks contained within this book, this chapter introduces the 'Heart, Head and Hands' model to capture an experience that is relational, emotional, caring, physical, and experienced within the physical environments or contexts of care.

Tips for Practice Educators

As discussed, meaningful moments can happen during the ordinary shared experiences between the service user and the student. Students need time with the service users to develop relationships and learn about the individual's or group members' likes and dislikes.

Beginning of placement: Where possible, give the student specific tasks in the commonly used rooms in your service, for example the kitchen. Loading and unloading the dishwasher enables the student to start casual conversations and observe service users' different drinks and food preferences. Encourage the student to invite service users for tea and a chat, when they can get to know each other better.

Middle of placement: This is the time for the student to introduce activities that will appeal to the service users and will offer them alternative experiences and opportunities. For ideas on creative activities, go to Chapter 75, but here are a few to get you started:

a. Look at communal spaces – do they reflect the people living or working there? What about doing a photo collage of shared memories between the staff and the service users to hang on the wall?

b. No place like home – show the service users and staff photographs of different rooms on Pinterest, and ask them to select the room that feels most like home. Look at simple ways you could use these ideas to make the communal spaces feel more like home to everyone who lives there.
c. Create photo albums with individual service users of their likes and dislikes, meaningful people and places.
d. Make individual 'memory maps' of all the local services that you can visit together.
e. Make a space in the day for everyone to sit, drink tea and share their 'meaningful moment of the day' story.

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Chapter 73 – Paul Creaven

Domain 5 Standard of Proficiency 12

Demonstrate safe and effective implementation of range of practical, technical and professional practice skills relating to the specific needs of the service user in a range of social care settings.

KEY TERMS

Professional skills
Practical skills
Technical skills

Social care is … an opportunity to support people and support them in using their voice.

TASK 1

List the professional, technical and practical skills that you think are the most important for a social care practitioner to have.

Professional Skills

Professional Skills		
• Communication	• Initiative	• Advocacy
• Adaptability	• Team player	• Self-care
• Empathy	• Non-judgemental	• Self-reflection

Professional skills in any job or career are the skills that you, as an individual, bring to your practice. These skills include communication, adaptability, empathy, being non-judgemental, advocating, showing initiative, being a team player, self-care and self-reflection. While not explicitly presented as a module in some colleges, these skills are more evident to a student during college placement. If these skills were not obvious to the student on placement, this is where the responsibility of a supervisor comes in (Rochford 2007).

As well as exploring skills, this chapter introduces traits, which are more personal and involve the nature of the work. We are, as professionals within services, part of an individual's world, their life, goals and ambitions. This first professional skill this chapter focuses on is communication.

Communication

One of the most vital professional skills a social care worker can possess is the ability to communicate, whether with a service user, their support network, or when you are speaking on their behalf to your team. If a practitioner is not a good communicator, either a listener or speaker, the majority of other professional, practical and technical skills can become redundant. A good communicator in the field will be able to actively listen to a service user or group, adapt their own communication (tone of voice, how fast they speak, words they use to describe something) to suit the needs of a service user or

group; they may even demonstrate negotiation skills (Shannon 1948). While the first two parts of this skill will be required every day in your role as a social care worker, the skill of negotiation will be required only every now and then; perhaps to convince a service user to come into a day service or even to support an individual in residential care in getting out of bed in the morning. Communication is vital in supporting the service user in making informed decisions in their lives and it is central to our practice.

An example of adapting communication to suit the needs of a service user includes supporting an individual with difficulty in verbal communication. This may require having a pen or paper with you when talking to the individual, having pictures of general items, or even changing the environment you are in to suit their needs.

Empathy and being non-judgemental

Being able to communicate in a positive manner will enable a social care worker to develop empathy for a service user. Empathy is the ability to understand how someone feels (Statham 2007). With empathy, a practitioner in the field can support a service user through difficulties in their lives. In order for a social care worker to be able to develop empathy while supporting a service user, it is important to remain non-judgemental. There may be periods in our career when a service user's belief system or actions go against our own attitudes and values. It is extremely important that this is recognised by the practitioner; however, we must not let that cloud our own judgement while we provide support.

The difference between sympathy and empathy can be explained in the following example. If somebody is affected by an acquired brain injury, it may prevent them from working, driving or socialising. Showing sympathy is feeling sorry for the individual. Empathy is understanding the hurt felt by the loss of independence, understanding the grief somebody may feel by not being able to drive their children to events any more or relying on people to bring them to appointments. Being non-judgemental could be understanding the individual and their hurt, responding appropriately if there is a change of personality or decision-making due to the acquired brain injury, rather than directly pointing out the inappropriate behaviours that may be demonstrated. It is about separating our personal values and norms from our work and focusing on supporting the individual.

Advocacy, initiative and being a team player

With an understanding of how a service user (or group within a service) feels, a social care worker can become an efficient advocator on their behalf if required. To advocate for someone is to support them with their needs within a service or externally within the community. To advocate for an individual or a group, a practitioner must first understand their need and how advocating can overcome it. The social care worker needs to ask questions such as to whom and how they should advocate (Inclusion Ireland 2020).

The most common example is supporting an individual in being accepted for Disability Allowance after an appeal. The process for the worker involves supporting the service user and their family; explaining what happened and the process that must now be followed; getting in contact with relevant external agencies; and even speaking on the day of the appeal. Group situations might involve supporting a group of service users in getting a bus stop closer to a day service or even advocating for a set-down area outside a day service. The impact these supports have on a service user (or their family) can be enormous. Quality of life, feeling safe and feeling listened to are just a few things that a service user may feel when someone listens and advocates for them.

It will quickly become apparent to a social care worker, no matter how much they use their own initiative while supporting a service user, that being able to engage in a team has a great impact on the quality of service a service user receives. Some of the work requires a multi-disciplinary approach, whether that is internally within a service or externally with social, community or medical agencies. When you work in a team, knowing who you are in it, the goal and responsibility you have for achieving that goal is vital.

A team working together within a service for the benefit of a service user might include the service user's key worker relaying information to other staff about the service user's person-centred plan or support plan. In a day service this may present itself in information being passed to other staff members. For example, the type of medication the service user is on or the risk assessment of a service user being updated and staff informed. A person-centred example is all staff members supporting a service user, not just the key worker involved in the service user's goals. Group facilitators and one-to-one support all support the service user in achieving their goals. Working productively in a team could open many opportunities to a service user that may not have been possible if they were only working with one social care worker. While we are working with the lives of vulnerable children or adults, we must acknowledge that we sometimes do not have the appropriate skill set or tools to support someone with a specific need. A multi-disciplinary approach to social care work enables the service user to access a variety of professionals, where appropriate; mental health (counselling, psychology), specialised rehabilitative support (speech and language, occupational therapy), employment support (job coaches, guidance counsellors) and professionals to support physical health, from the doctor to the personal trainer.

Your role as a social care worker could be to sit down with specialists and the service user and then you all come together to create an action plan that allows the service user to make use of the skill set of external agencies. When advocating we are expressing the wishes of service users and supporting their right to choice. This is achieved by also ensuring that the service user is aware of and understands the information that they are receiving, whether oral or written.

Adaptability

As a social care worker, your role is about guidance, support and assistance. In a single day, a practitioner's role in one day could involve supporting the same individual with their personal needs, facilitating their workshop and then being the person they want to talk to because of the argument they had with a family member at the weekend. A social care worker may play a number of characters on the same day for the same person. Indirectly, you may also be speaking on behalf of a service user, receiving information on behalf of a service user or supporting a service user with referrals for health or welfare services.

A normal day for a social care worker may require them to change their approach with various individuals – service users, family members, other social care workers or professionals in other services. These changes could involve different uses of language or different types of support provided to a service user.

Self-care and self-reflection

TASK 2

List the things that you enjoy and that help you to switch off from work or college. What type of exercises do you do to help you self-reflect?

All the roles, attributes and styles that social care workers possess, however, mean that self-care is such an important skill. Without it, a social care worker cannot protect themselves from the traumatic lives of service users. If they cannot support themselves, they will be unable to support a service user. Self-care for a practitioner involves being reflective, observing the worlds of service users, understanding if these worlds are going to impact on you personally and, most important of all, knowing your limits. Social care workers need to know when to switch off and, when they do clock off, to know how to look after themselves. It is a professional skill that can reap benefits for the practitioner, the service and, most important of all, the service user. It is an attribute that is personally and professionally an enormous asset to a social care worker, but it can be one of the most neglected. This is, ironically, due to our desire to help and support those who are entrusted to us as professionals in our own field.

Self-care from a work point of view is not being overworked and having appropriate supervision. Personally, it is all about what makes the social care worker step safely from the worlds of service users and into their own personal lives. It could be exercise, hobbies, keeping a journal or even having a check-in with a counsellor or supervisor external to work.

Practical Skills

Practical Skills	
• Report writing	• Formal training
• IT skills	• Knowledge of service user profile
• Induction	• On the front line

Report writing, IT skills and induction

An organisation may have policies or procedures that then determine how they approach report writing, how service or goal plans are put together and how risk assessments are compiled.

Being IT efficient in a social care environment means being competent with emails, using applications such as Word and PowerPoint and whatever IT system an organisation uses to store service user information or statistics. This can even extend to being an administrator for an organisation's website or social media accounts.

The service type may then determine if the ability to work in groups, one-to-one, in a training environment, in the community or within a home is appropriate. Is the goal of the service to support with community skills or independent living? Is it to support with developing vocational skills for work or rehabilitative skills to enable someone to cook and clean for themselves? The advantage of being able to describe what type of service an organisation provides is that it enables an organisation to state the type of professional they are looking for and to develop a training programme for staff that suits the service. For example, if a staff member is expected to run groups, training on workshops can be provided; residential staff may have training on supporting service users with taking their medication.

Formal training

Leading on from that, funders may have expectations about the type of formal training social care staff have when supporting service users within a service. Staff working on vocational programmes may need formal training in providing group training to service users. Formal training can also include manual handling, first aid, children first and safeguarding.

Knowledge of service users and being on the front line

Last but not least, the profile of service users who the service is geared towards must be taken into account. Then, a service needs to ask if it is the appropriate service for those needs and what skills are needed to ensure that a service user is safe. The practical skill set for physical needs may be support for eating, for personal needs such as toileting, or even something as simple as assisting someone to close their jacket. Knowledge on the service users profiled for a service is important. A service could, for example, be for individuals diagnosed with an acquired brain injury or an intellectual disability. A social care worker is not expected to be an expert on a diagnosis, but they should at the very least know how the symptoms of a diagnosis may have an impact on someone. Take an acquired brain injury, for example: a social care worker is not expected to know the brain like an expert in neurology; but the should at the very least understand the possibility of memory difficulties and the affect on cognitive processing, and the impact such an injury can have personally on someone. A social care worker needs to have the skill of researching these impacts and how they might affect someone's life.

The nature of social care and the services that are associated with the profession, being on the frontline can mean very different things to each individual social care worker. Within a vocational service it could mean providing support on IT or literacy skills. For a day service it might mean providing therapeutic groups and facilitating art groups, music groups and meditation groups. In a residential setting it could involve supporting a service user with personal skills such as washing, making breakfast and grocery shopping. For this author, while working in a training centre supporting individuals diagnosed with acquired brain injuries and strokes, front line meant supporting one-to-one in the community, facilitating brain injury education groups, maths groups and IT skills, and also facilitating walking soccer groups, mini tournaments for table tennis and even supporting an external facilitator for yoga. Supervising lunch breaks and providing support for personal needs can also be added to this list. It may be difficult to believe, but all this happened in one training centre for one staff member. This does not include the different responsibilities of other staff members.

Technical Skills

Technical Skills	
• Risk assessment	• Person-centred plan
• Positive risk assessment	• Service review
• Support plan	• Session notes

Technical skills involve putting professional and practical skills together, resulting in a service that is directly linked to a service user. Whether it is positive or negative depends on the ability of the social care worker. Technical skills include putting together an appropriate risk assessment, positive risk assessment, support plan, person-centred plan and service review, and compiling session notes. While a social care worker gets training in this from their service and is aware of these concepts though academic learning, in practice it is now about the ability of the social care worker in using their own professional skills, the appropriate practical skills and tying them both together.

As mentioned at the start of this chapter, without being skilled in communication, it will be very hard for a social care worker to interact with a service user in a way that allows the successful implementation of these technical skills. Unfortunately, this skill set may at times involve the social care worker having to give a service user bad news. This could be due to a risk assessment or limited resources within a service or the community not allowing the completion of a goal in a person-centred plan; or having to record or write up session notes after a challenging incident with the service user. While we do not like giving bad news to anybody, either personally or professionally, it is important that service users are informed, that they understand what is being said and that it is done in a non-judgemental environment.

Risk assessment

A risk assessment is about the social care worker assessing the needs of an individual or group, identifying the risks, understanding the severity of the risk and then identifying ways to reduce that risk. It must be understood that nobody expects a staff member to get rid of every possible risk – that would nearly stop a service from even happening! It is about figuring out risks, and preventing or minimising them. This applies as much to staff as it does to service users. It must be understood as well that it is not about stopping a service or activity. This is all about the skill the staff member has in creating a safe environment (as much as is reasonable) to allow something to proceed. For example, if there is a group activity out in the community for a day service and part of the plan is to walk to the activity, a risk assessment is completed for the group and individually. If there is a service user who has balance or co-ordination difficulties and issues with their peripheral vision, it does not automatically exclude them from the activity. A service can put a plan together that would allow that service user to have one-to-one support. The risk assessment would also look at the staff member/volunteer/student on placement supporting the individual by directing them away from the edge of a path on a main road or, if that is not possible, staying on the side that is most at risk of causing a fall/serious injury. Risk assessments need to be viewed as instruments that allow us to put in place procedures, where possible, to allow an individual the same chance as everyone else, not as something that restricts the chances someone has to participate. It needs to be accepted, though, that occasionally a risk assessment will show that an activity cannot happen because the risk and likelihood of injury to the service user and/or staff members is too high.

Positive risk assessment

While the risk assessment takes a health and safety point of view, a positive risk assessment assesses the risks associated with the goals a service user may have and using the positives of that goal as a measure. This is a skill usually used when discussing goals with a service user's family members. They may be quite anxious about something going wrong with the goal. The aim of the social care worker is to ease those anxieties and prevent them having an impact on the service user. A perfect example of this is if a service user wanted to get gym membership or take part in an exercise group in the community. One of the most common fears family members have is that their son/daughter/brother/sister may get injured. The appropriate approach is to acknowledge that there is a chance that could happen but to point out that getting injured is the same for everybody who does this activity. The positive part of this assessment is to then point out the benefits, for example exercising, community participation and social interaction. The social care worker needs to show that the positives outweigh the negatives.

Support plan

Both these risk assessments will pull information from a support plan (which may have a different name, depending on the organisation). A support plan identifies the needs of the individual, which are then acted on to enable them to participate in a service. Again, this is not about the social care worker pointing out limitations to stop a service user participating in activities. It is about the social care worker putting things in place to make participation possible. This is part health and safety, part guide. The service user is also aware of the support plan. It is important that a key worker asks a service user what they feel should be on the support plan or let them know the reasons why something goes on it. A support plan may look at physical, mental, emotional, cognitive, living skills and social needs. This all depends on the type of service. The support plan is vital, as it complements the person-centred plan that a service user has within a service.

Person-centred plan and service review

The person-centred plan (PCP) for a service user is the plan that directs an individual's service. A technically astute social care worker can support a service user in identifying goals they would like to achieve, ensure they are realistic for the service user, specify to the service user the steps involved in achieving the goal and support them in creating realistic deadlines for goals. A social care worker also needs to be able to come up with contingencies if steps need to be adjusted. One of the most important skills a social care worker can possess when supporting a service user, when putting together a PCP, is the ability to look long term at how goals can progress and benefit a service user. One example might be the benefits of upskilling on a computer. From a goal of being able to turn on a computer, a service user's PCP around technology could lead to using emails, online shopping, online learning and completing a part-time or full-time course. From those goals comes the added achievements of a new way to communicate, educational success, the opportunity to be part of a new community in a college, to potentially achieving a level of employment. A social care worker needs to be able to tie all this together while respecting the service user and the goals they would like to achieve.

All of the above would then be transcribed into a service review: goals achieved; why certain goals were not achieved; and contingency plans that were put in place. This is completed, of course, with the input of the service review.

Session notes

Communication with the service user is transcribed into session notes. It is important for the social care worker to be objective but also empathic when writing session notes. While understanding the need to be factual, a social care worker must also make sure that they do not use personalised language or write their own views in session notes. A good exercise for a social care worker is to imagine that you are the individual the notes were being written about – how would you feel? Service users have a right to access their personal files, which include session notes. Session notes may also be required for legal reasons.

Good professional practice when writing session notes is to write objectively about the events of a meeting or session; notes should not read like the opinion of the social care worker. For example, writing in session notes that a service user cried when told something is appropriate; however, a social care worker cannot write that the service user got upset because the word 'upset' can mean any number of things.

Professional, Practical and Technical Skills Combined

Professional, Practical and Technical Skills in use

(What the SCW brings in from college or placement)

Professional

- Communication
- Adaptability
- Empathy
- Initiative
- Team player
- Non-judgemental
- Advocacy
- Self-care
- Self-reflection

(Determine ability to achieve technical skills)

Technical

- Risk assessment
- Positive risk assessment
- Support plan
- Person-centred plan
- Service review
- Session notes

(Determine the relationship with service user)

(Policies formed in service)

Practical

- Report writing
- IT skills
- Induction
- Formal training
- Knowledge of service user profile
- Being on the front line

(Determine the format of technical skills)

Service User

A blend of all three skills is required for the development of a service user's service in a social care setting. With that being said, communication is paramount for all three to work together. This applies to how a social care worker communicates within the field and how they take in any interactions.

In order for a social care worker to stay focused, reflection and awareness are vital components in the social care toolkit. Without them, the skills a social care worker has acquired or naturally refined may become dull and in the long term possibly result in apathy and even burnout.

One of the most important things for a social care worker to realise is that there is no such thing as a perfect social care worker. This is not a criticism of professionals in the field, but an acknowledgement that social care is such a personalised field. There will be times we cannot bring our best selves to work, but it is how we respond that counts. We also need to understand that if we are working in a service that may have as many as fifty service users, we cannot be everything for everyone all the time, despite our best efforts.

Above all, we need to accept that the environment we work in can be quite fluid, due to policy changes, new research on best practice, and legislation. It is our ability to adapt to these changes while ensuring the safety and quality of service to service users that enables social care workers to support individuals, groups and their goals.

TASK 3

1. Make a list of professional, practical and technical skills that are your strengths and the type of impact they can have on a service user.
2. Make a list of professional, practical and technical skills that you feel you could improve on and how they could benefit you professionally.
3. What strengths do you have that have not been included in this list?

Tips for Practice Educators

The stand-out words in this proficiency are *safe, effective, skills.* It is not just about knowing what the skills are but whether a student already has them, needs to work on them or has the skills to investigate how to increase their knowledge.

Professional skills or knowledge of professional skills can be explored through personal development or self-reflection exercises. A student can be asked to explain or describe how they believe these skills can support them in being a competent social care worker and provide a safe environment or atmosphere for service users. It is important that a student can not just list the strengths but also explain why they are strengths. While we point out their strengths, there is nothing wrong with asking a student where they feel they themselves can improve and how they can achieve that. As mentioned, self-reflection is something that a social care worker needs in their own toolkit. It will allow a student to self-analyse but allow them the opportunity to come up with solutions. In a way, it is their very own support plan when in the professional field.

From a practical point of view, before students become social care workers it would be a massive benefit to have some form of knowledge around the legislation that moulds the social care profession and also be aware of the areas of social care and the similarities and differences between them.

Exercises might involve:

- Giving students the legislation and asking how they feel it could impact their work and when it may become relevant.
- When looking at services, a great exercise would be to research services in the locality, ask to speak to staff and then compare and contrast with other students. Questions to ask would be: the role of a social care worker; the goals of the service; and how a service decides if the service is relevant to an individual.
- A simple exercise for a student to complete when considering the technical skills is to ask them to imagine being a service user in a service. What would they feel is important or relevant? This exercise could be completed in two stages: before a student goes on placement; and when placement has been completed. Compare and contrast the answers – what was different? The skills listed can be used as bullet points. What do they mean for the student? What do they think they mean for a service user? What type of communication is important to ensure a constructive outcome and positive relationship between the service user and the social care worker?

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Chapter 74 – Victoria Mc Donagh

Domain 5 Standard of Proficiency 13

Be able to integrate self-awareness, communication, working in partnership and professional judgement into professional practice to meet the need of the service user and empower them to meet their full potential.

KEY TERMS

Empowerment
Partnership advocacy
Relationship building
Self-awareness
Reflection
Professional judgement
Supervision

Social care is … about supporting people who need different supports at different stages of their lives. As a social care worker, I feel it is about being a guide to an individual who is the expert in their own lives, ensuring they are making informed choices and engaging in opportunities for their own wellbeing. As a service user once explained to me during our time together, 'You were the angel on my shoulder, helping me to guide my own life.'

Empowerment and Partnership in Social Care Work

In social care work there are many different settings and many different people a social care worker might work with. However, regardless of the setting or the service user in front of you, a social care worker should always work from a place of empowerment and partnership with the service user/s. Partnership and empowerment are two key concepts in social care, whatever setting you are working in. Partnership is about working *with* the person. Whether the service user is a child, an adult with a disability or an elderly adult, you work alongside that individual. The social care worker should be able to act as a guide and facilitate individuals to make informed choices, being experts in their own lives and their own support needs. This is what working in partnership looks in like in practice. In this instance the role of the social care worker is to listen and learn the story and journey of the service user/s. Then the social care worker works alongside them, provides support and encouragement to make positive decisions and choices in their own lives. Working from a partnership approach ensures that the service user is at the centre of the work.

This links with the concept of empowerment. In social care work we talk about the service user being the experts in their lives. When we work in partnership with them we can help them to achieve their goals and meet their individual needs. If as a social care worker we work from this perspective, this empowers the service user to be the leader in their story and situation. The social care worker is encouraging and trusting the service user to take control over their lives, promoting choice and decision-making. This is a powerful tool. Empowering someone can encourage that person to feel supported but also to continue on their journey. In particular, in social care work, when we talk about promoting and encouraging change, the best and most long-lasting change comes from within that individual person. This is empowerment. Empowering a person to make change to contribute to their lives in a positive manner can be the most important step in supporting a service user.

Consider This

In my early years of practice, fresh from my studies and working in the area of adults with a disability, a colleague explained to me that sometimes as staff and in the daily support needs of the service users, we can get busy and might want to hurry things along. That it could be quicker for us to make the service user a cup of tea instead of supporting them to make it for themselves. This colleague explained to me how this was the opposite of empowerment and partnership. That making this cup of tea could, for the service user, be the mountain they chose to climb; and what a difference it could make to them when they are supported to achieve this. While making a cup of tea for one person might be part of everyday living, almost second nature, to another person it could represent independence and progress. When I hear the words 'partnership' and 'encouragement', they still remind me of that time and how important those concepts are in social care work.

Self-Awareness and Communication in Social Care Work

As described above, the social care worker should be able to act as a guide and facilitate individuals to make informed choices, being experts in their own lives and their own support needs. This represents the concepts of partnership and empowerment in social care. How a social care worker works within this aspect of practice can be both rewarding and also present challenges in practice. Challenges may arise from the service user and their actions and behaviours; but it can also arise from the skills and abilities of the social care worker. A social care worker's self-awareness, communication skills and professional judgement are important elements here. Professional judgement is our education, training, knowledge and skills all used together in practice to make decisions and judgements about our work every day when working with service users. Therefore, it is extremely important for any social care worker to continuously work on their self-awareness and communication skills, to be able to work in partnership with service users, but to also to have an awareness of their own judgements, values and attitudes that could present as potential barriers to their practice.

I have worked with children from as young as three up to adults in their elderly years. While each individual had different needs at different stages of their lives, I always strived to work 'with' them. Working with the person includes working in partnership and putting them at the centre of their support and care. This approach also includes being able to adapt and put aside the time needed to build a relationship. Sometimes it may take longer, depending on the complexity of need and the situation of each person. However, I found when I took this approach that it helped to build a genuine and trusting relationship. Working in social care is also about creating this support as part of a team. How social care workers interact and communicate with each other can also impact upon their relationship and work with the service user/s.

TASK 1

Reflect on how two workers, for example, may communicate to one another in the presence of service users.

Is the language that both workers use appropriate, not only to the setting but to that particular service user?

Does this language reflect the needs of the service user but also respect and empower them?

Does the service user understand the language being used? Do the workers check in with them, using the service user's language of how they describe their needs and story?

This can be a powerful tool in social care work, when striving to build a relationship and empower a service user. For example, think about a service user sitting in a case conference about their support needs and care. Imagine if that individual did not understand what was being said about them and their disability because the language being used was not their language. That they do not understand, but they are too frightened to say otherwise. This is an isolating place for a service user, a disempowering place. A social care worker must check in with the service user that they understand, but also is their voice and view truly being heard and represented. This is working in partnership and working from a place of empowerment.

TASK 2

Think for a moment about your own communication style. Do you really listen? Do you adapt your communication style when needed?

Developing skills such as self-awareness is not about being tough on yourself; it is about developing the ability to reflect on your practice. Examine your own values, beliefs and attitudes and their interaction with your practice. Being honest with yourself, do you let any of your own attitudes, values or beliefs get in the way in working with service users? How do you use these values, attitudes and beliefs in a positive way to enhance your practice? This is not about being a negative cheerleader for your work – it is the opposite. It is a healthy process in a safe and comfortable environment for social care workers to check in with themselves. Within the practice setting it may be about using formal supervision to engage in this process, or having an informal discussion with a colleague. Developing your own self-awareness is about seeking out a time and place where you can do this. Spending time developing your self-awareness will enhance your skills and abilities to work in partnership with and empower service users.

The concepts of partnership, empowerment, communication and self-awareness are connected with each other in social care work. It is important to work on each of these in order to truly work with the service user/s and their support needs. This is represented in the diagram below.

The Social Care Worker's Toolkit

It was once explained to me that social care workers carry with them their own toolkit, just as a mechanic would carry a toolkit. Our tools are the skills, abilities, values, attitudes and professional knowledge required for practice. Just as a mechanic would look after their tools, social care workers need to do the same. Doing this not only contributes to good practice with service user/s, it also develops and maintains the wellbeing of the worker. When a social care worker is looking after themselves in this way, it heightens their self-awareness, develops their communication skills and makes a positive contribution to their role in a social care team (Sanderson & Lepkowsky 2014).

- What is in your toolkit? Can you identify some skills, knowledge, attitudes and values that you use in your own practice?
- Why are these particular tools important to you?
- How well do you care for your tools? How well do you look after your own wellbeing? Are there any areas you would like to improve upon?

This may also be used in supervision with a social care worker or student.

The social care worker's toolkit requires continual care. This is the work achieved through reflective practice, supervision and continued personal and professional development opportunities.

A Helpful Resource

This five-minute video looks at person-centred care in social care work and at the impact of partnership and empowerment for service users: https://www.scie.org.uk/person-centred-care/what-is

Summary

This particular proficiency examines how you work in partnership and empower those you work with in social care. It goes further, exploring what skills and abilities are required by a social care worker in order to achieve this. It explores the social care worker's sense of self-awareness, their communication skills and how they use their professional knowledge to achieve this. This proficiency is explored by looking at how social care workers can strive to work in partnership and empower service users to reach their full potential. All those you work with in social care have unique needs and lives and this must be at the centre of everything you do.

Tips for Practice Educators

This reflective activity may assist both placement supervisors and social care educators to explore this proficiency with students. Within the classroom it may be appropriate for students to explore these questions in small groups.

- Can you think of a time where you felt empowered?
- Can you reflect on how you felt and what thoughts you had at the time?
- What made you feel empowered? For example, was it something somebody said or someone's actions?
- Why does this feel important for you? Or why does this particular experience stand out?

This task can help to develop self-awareness and empathy for the social care worker/student. It can also be used in a supervision session, where appropriate.

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Image Credit: St Patrick's Mental Health Services. Available at <https://www.stpatricks.ie> [accessed 28 May 2020].

Chapter 75 – Teresa Brown and David Power

Domain 5 Standard of Proficiency 14

Be able to identify and understand the impact of social care history, organisational, community and societal structures, systems and culture on social care provision.

KEY TERMS

Institutionalisation and seclusion

Professionalisation and deinstitutionalisation

Secularisation, specialisation and accountability

Crisis and change

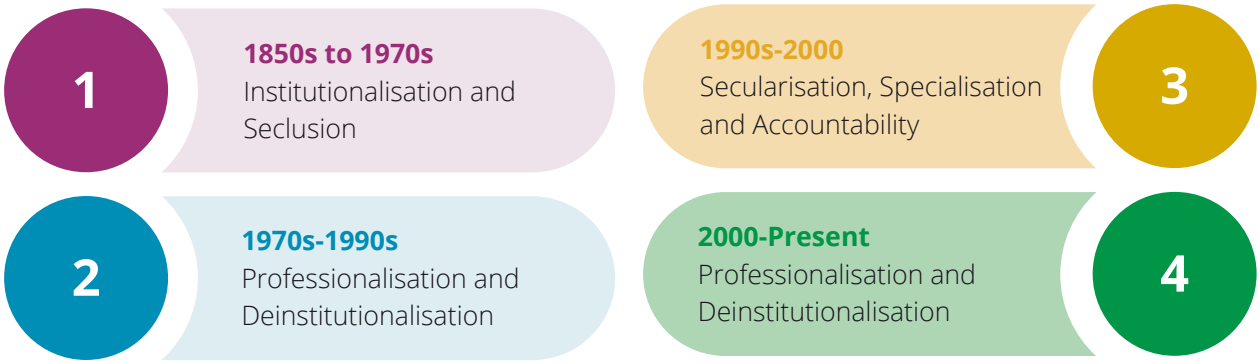
Social care is … in its simplest form, supporting, protecting and helping vulnerable people to maximise their potential. However, social care is not simple. It is a journey of growth and learning. A way of providing resilience, but also being resilient. It is a way to promote change in people's lives. It encourages people to be real. It is caring and kind when things become difficult and teaches by example with patience, trust, care, self-love and courage. It is unconditional to the needs of others. It is holding the dreams and hopes of traumatised young people. Social care feels pain and understands the lasting hurt from childhood experiences, and from the past, both theirs and ours.

Introduction

A complex interplay of socio-political and economic factors has impacted on the wider context within which social care provision has emerged and has been shaped and delivered. At the current time, there is a concerted effort to professionalise, specialise and regulate the sector with the aim of improving outcomes for children, young people and families. Central to this reform is the need to *understand the impact of social care history, organisational, community and societal structures, systems and culture on social care provision.* There is no doubt that there is a tendency to distance ourselves from our history, such was the scale of physical, sexual and emotional abuse suffered by children in institutions run by a range of religious orders which were funded and inspected by the Department of Education. However, as McGregor (2014) argues, we must move beyond feelings of shock and shame at the failings that have been exposed and learn from the problems of the past and from their specific contexts.

This chapter provides a brief history of the key developments in our social care history. While locating the discussion within this wider context, the primary focus will be on the history of care for children. Changing ideologies and discourses and their consequent positive and negative impacts on social care provision and policy are highlighted. The catalysts and constraints which have shaped social care provision will be discussed.

The emergence and development of residential childcare has been chronicled by Gilligan (2009) into three periods of development: institutionalisation and seclusion (1850s to 1970s); professionalisation and deinstitutionalisation (1970s to 1990s); and secularisation, specialisation and accountability (1990s-2000). To this, we have added a fourth category to denote developments from 2000 up to the present day. We have entitled this 'crisis and change', given the dominance of historical institutional abuse inquiries over this period, the challenges that have arisen and the changes that are emerging.



Institutionalisation and Seclusion

The first phase, from the 1850s to the 1970s, demonstrates Ireland's unique socio-cultural composition. The development of policy was shaped by the influence of the Roman Catholic Church and the State remained at the periphery in all areas of residential care provision. Historical literature paints a picture of residential childcare as both positive and negative. On the one hand, thousands of destitute, orphaned and/or abandoned children received care, often for many years, and they were supported into adulthood (Barnes 1989). Thus residential child care played a pivotal role during a time of enormous hardship in Ireland.

On the other hand, writers also depict the geographical seclusion of these large institutions, isolated from the outside world, where contact with families was actively discouraged and, in some cases, prohibited (Barnes 1989). These practices were not criticised at the time because provision of residential childcare was underpinned by a 'rescue model' (Gilligan 1991) of childcare provision, where children were saved from unsavoury conditions. O'Sullivan (1979) depicts this model in his references to the Lord Chancellor's speech in 1870 where childcare provision is described as 'giving so many useful citizens to the State, so many immortal souls to heaven and rescuing thousands from lives of penury and sin who would have lived and died in crime and misery' (O'Sullivan 1979: 211).

Reformatory schools were established by statute in 1858 for young offenders over the age of 12, in order to end the practice of sending young people to jail. Subsequently, the need for a different type of institution to cater for young people in need of care, and who were not offenders, was recognised. Ten years later the institution of the industrial school, first established in Scotland, Wales and then England, was extended to Ireland in 1868 after Irish parliamentarians advocated for its introduction (Craig *et al.* 1998). Industrial schools were described as schools 'for the industrial training of children, in which children are lodged, clothed and fed, as well as taught' (Children's Act 1908, Section 44). Reformatory schools were defined in the same terms, but with the substitution of 'youthful offenders' for 'children' (Robins 1980). Despite being largely state-funded, these institutions were managed by religious orders (Raftery & O'Sullivan 1999), with the state adopting a subsidiary role in their management (Robins 1980), thereby allowing religious organisations to run the institutions without state interference.

The rescue model underpinned provision. It was informed by a social risk model of care, in which children were perceived as a social risk and a threat to society (O'Sullivan 1979) and the aim was therefore to mould males into hard-working working-class adults (Raftery & O'Sullivan 1999) and females into 'the living embodiment of Our Lady – humble, pious, celibate' (Inglis 1998: 248-9). Children were viewed as moral subjects, with the emphasis being on conformity (Smith 2007). Consequently, industrial and reformatory school systems were harsh regimes. However, it was only years later that it was realised just how harsh and cruel the were. The Church-State relationship constructed what Smith (2007: 45) terms 'Ireland's architecture of containment', a term explained below. In addition to industrial and reformatory schools, there were other interdependent institutions, such as mother

and baby homes and Magdalene laundries. Behind the walls of these institutions were members of society marginalised by a number of interrelated social phenomena including illegitimacy, incest and infanticide (Smith 2007).

In the mid-1850s, as an alternative to the state-owned, religious-managed facilities, voluntary organisations became involved in the provision of care for children. One such organisation was Mrs Smyly Homes. The founder of the organisation, Ellen Smyly, stated that in the 1850s it was nearly impossible to walk the streets of Dublin without being chased by children begging for pennies to buy food. Her first school opened in 1852 in Townsend Street. Smyly Homes began by providing education and accommodation for deprived children of Dublin, and it has maintained this value and approach to care.

TASK 1

Watch the YouTube clip 'Courageous Campaigner – a tribute to Christine Buckley'.

Professionalisation and Deinstitutionalisation 1970-1990s

In 1970, the Report of the Committee of Inquiry into Reformatory and Industrial Schools' Systems (which became known as the Kennedy Report) was published. It was generally viewed as a pivotal moment in childcare history. It set the course for the future development of childcare provision while also reflecting changes that were already afoot under several broad themes: deinstitutionalisation; diversification; regulation and professionalisation of the workforce.

With regard to deinstitutionalisation, by the time the report was published in 1970, the residential childcare system had greatly declined. Between 1964 and 1969, fourteen industrial schools were closed at the request of the religious orders. The decrease in the number of children in residential care and the increase in the use of foster care reflected both international trends and particular features of Irish society; fewer people were entering religious orders, and state finance to support voluntary and Church-based providers of residential childcare had been reduced (Buckley *et al.* 1997).

Although the process of the closure of industrial schools had already begun, the Kennedy Report reiterated the necessity of this, with Justice Kennedy being 'appalled' by their 'Dickensian and deplorable state'.

> The whole aim of the childcare system should be geared towards the prevention of family breakdown and problems consequent on it. The committal or admission of children to residential care should be considered only when there is no satisfactory alternative (Kennedy 1970: 6).

Reiterating the recommendation of the Tuairim Report (1966) that staff should be fully trained in the various aspects of childcare, the Kennedy Report (1970: 13-14) also stated that the provision of trained staff should take precedence over any other recommendation and highlighted that 'neither affection nor common sense is sufficient by themselves'. However, despite the positive support for the findings of the Kennedy Report, the Association of Workers with Children in Care expressed some reservations that a group model of care 'could not provide for the majority now in need of care, the children with problems' (1974, cited in O'Sullivan 1979: 45).

After the publication of the Kennedy Report in 1970, there were major changes in both child policy and practice. Subsequent policies and reports reflected and reiterated the view that residential care should be used only when no satisfactory alternative was available. Social workers were given primary responsibility for supporting families in need and placing children into care. This move was reflected in the Boarding Out Regulations (1983) which formally required a Health Board to place a child in residential care only where it was not possible to place him/her in foster care. Arising from the Kennedy Report, it could be argued that the positioning of residential childcare as an intervention of last resort was sanctioned and reinforced. On the other hand, the residential childcare sector continued to provide care for children and it was positively impacted by the growing emphasis placed on: understanding children's needs; the workforce; and delivering care in a context where roles, responsibilities and regulatory frameworks were clear. For example, in relation to conceptualising and understanding children's needs, the Kennedy Report depicted a shift in the discourse of the child. Smith (2007) highlights how these shifts in constructions of childhood were informed by scientifically informed conceptions of childhood, such as developmental psychology. A more positive view of childhood emerged during this era with developments depicting the recognition of a developmental model of care, replacing the 'social risk' model of childcare, whereby the child was seen as a potential threat to society rather than someone with needs and rights (O'Sullivan 1979).

The aim of the course was 'to enable Residential Childcare Workers to cater for the basic living needs of children [...] and be able to provide therapeutic care for those who are quite seriously disturbed' (Brennan 1971: 5).

With regard to the workforce, the infrastructure of the residential care system was radically changed, with religious orders retreating from provision as a result of shrinking recruitment and an ageing profile in their congregations (Barnes 1989; Gilligan 2009a). As a result of this decline, lay personnel were employed in residential care centres. The decision to recruit lay staff effectively introduced the discipline of social care childcare in Ireland. Residential childcare workers employed in industrial schools were seen as purveyors of Church values and were expected to support the young people in their care to develop these values (Doyle & Gallagher 1996).

This strategy resulted in the continuation of an untrained workforce, as noted by the Kennedy Committee, which stated that there was 'a tendency to staff the schools in part at least, with those who were no longer required in other work rather than with those specially chosen for childcare work' (Kennedy 1970: 15). However, it is also within this context that positive moves towards professionalisation of the workforce also emerged. The first residential training course in childcare was initiated in 1971 in the School of Social Education, Kilkenny, signalling the start of the journey to professionalise residential childcare.

The significance of the move to professionalise the workforce, which gained further traction later, was that it signified an acknowledgement of the particular needs of children in residential childcare and challenged the view that children need only to be '*lodged, clothed and fed as well as taught*' (Children's Act 1908, Section 44). 'House Parents' was a title ascribed to the residential worker (Joint Committee on Social Care Professionals 2002) to reflect 'normal' family structures.

These positive outcomes of the Kennedy Report (1970) and reports from voluntary advocacy groups, including the Tuairim Report (1966), and *Children Deprived: The Memorandum on Deprived Children and Children's Services in Ireland* (CARE 1972) were indicative of the move of the state from a peripheral position to centre stage in the delivery and organisation of residential care provision. Although positive developments were being made, challenges were still evident; for example, residential care was managed by three separate government departments until 2007, and there were concerns regarding broader governance arrangements as no single department had overall authority over or responsibility for children in care.

A further positive change was the establishment of the Task Force on Childcare Services in 1974. A year later it submitted its Interim Report, the recommendations of which focused primarily on the provision of additional residential services for Travelling children, young children, residential facilitates for boys and residential facilities for girls. One section of the report was dedicated to setting up on a pilot basis 'Neighbour Youth Projects' for children at risk. The common theme in the recommendations centred on residential services for young people who were described as 'severely disturbed' or young people 'too difficult or disruptive for existing facilities' (Task Force 1975: 9). In addition, identifying the training needs of residential childcare staff was considered a matter of urgency. Five years later the task force's final report was published, as was a minority report reflecting the alternative views of two of its members (O'Cinneide & O'Dalaigh 1980).

'Childcare workers will constitute one of the most important resources of the childcare system. We consider that changes are urgently needed to improve training facilities for childcare workers, to improve their salaries and career prospects and to develop the organisational structures needed to support them in their work' (DoH 1980: 401).

Despite this progress, many subsequent developments reinforced the pervading discourse of residential childcare as a 'last resort'. For example, the broader-based recommendations of the Task Force strongly favoured foster care and it emphasised the importance of prevention and community-based family services programmes. Furthermore, the report identified how this process could be achieved, suggesting that a specially trained worker could be instrumental in enabling some deprived children to continue living at home (DoH 1980: 21). Hence, in the early 1990s, this recommendation afforded opportunities for many residential workers to be appointed on multi-disciplinary teams in statutory services as community childcare workers, a title still used today. The importance of supporting residential workers was a dominant theme in the report.

The guidelines identified '*skills in sewing, cooking, crafts and music are very useful as much of the day-to-day routine is taken up with looking after the physical needs of the children, washing clothes, cooking dinner and playing with the children. Applicants must have a good standard of education and a sound religious set of values*' (cited in O'Sullivan 2009: 176).

The Association of Workers with Children in Care, commenting in 1982 on the report's recommendations, stated that 'we plead loudly for our inclusion within a comprehensive plan' (O'Sullivan 2009: 403). (Interestingly, this theme of seeking inclusiveness in policy formation is echoed today by Social Care Ireland.) Workforce issues continued to dominate this period. In November 1979, for example, guidelines on the recruitment of childcare workers were issued by the Resident Managers' Association, the Department of Health and the Department of Education.

TASK 2

While the history of the children's experiences is now on record, it must also be acknowledged that many carers had given great commitment, care, concern and warmth, mostly at great cost to themselves -unsupported, unacknowledged and in pretty impoverished conditions. There was no thirty-nine hour week, no salary scales and always a dearth of staff, especially men (Pat Brennan Director of first training course for social care workers).

Q. Reflect on what it was like to be a social care worker at this time.

Secularisation, Specialisation and Accountability 1990-2000

Developments during this period are best understood in the context of changing ideological, political and economic factors. As indicated earlier in this chapter, the development of childcare services up to this point reflected the positive and increasing recognition of the needs and rights of children, the need for specialist provision and the requirement for service delivery to be underpinned by a trained workforce. However, this was coupled with ongoing concern about the quality of day-to-day service delivery. In the 1990s, with the growing influence of neo-liberalism, the effect on the residential childcare sector was an increased emphasis on accountability, managerialism and bureaucratisation. These developments ran concurrently with an increased emphasis on the rights of the child.

Turning first to the rights of the child, from the early 1990s recognition of the need for changes in policy and practice in relation to children gained impetus (Nolan & Farrell 1990). In 1992, Ireland ratified the UN Convention on the Rights of the Child (UNCRC), which provides a framework within which to develop and critique policies related to children. The conceptual paradigms of childhood were changing, with children's needs beginning to be constructed more within a discourse of rights (Smith 2007). Developments in our legal framework provided further evidence of changing attitudes towards children. The Childcare Act 1991 replaced the Children's Act 1908 after a gestation period of 25 years (Gilligan 1993), arguably indicative of society's complacent attitude towards the welfare of children.

Specific changes in the Act included: extending the legal definition of a 'child' from the age of 16 to the age of 18, thereby prolonging the period of childhood; the introduction of a range of new orders, such as the emergency care order, which authorised the removal of a child or the retention of a child in the custody of the Health Board for a maximum period of eight days. Furthermore, an interim care order was introduced, this being a new short-term provision which could be made where an application for a care order was likely or pending. The care order committed a child to the care of a Health Board until their eighteenth birthday or for a shorter period. The Act also placed a statutory duty on Health Boards to provide family support, and set out the powers and duties of Health Boards with regard to children who were in their care. In addition, provisions under the Act required that consideration be given to the wishes of the child, having regard to the age and understanding of the child (Ferguson & Kenny 1995).

Monitoring compliance with the regulations was carried out by the Health Boards until 1999, at which time the Social Services Inspectorate (HIQA) was established on a statutory basis. The key area of change, as noted by Richardson (2005), following the passing of the Childcare Act 1991, was that there were increasing efforts to regulate and standardise procedures and practices in child welfare services.

Turning to neo-liberalism and the combined influence of discourses regarding accountability, managerialism and bureaucratisation, evidence of their hold on residential childcare provision can be seen in relation to the identification and management of risk (Webb 2006), with discussions 'dominated by emotions of fear, an undermining of trust and the wish to control' (Parton 2001: 69). This became evident in the broadening of the residential care landscape to meet the needs of young people considered 'at risk' or 'a risk'. Consistent with previous studies, the overall picture that emerges from much of the research (Focus Ireland 1996; Craig *et al.* 1998; during this period centred on the difficulties of the residential care system in dealing with the 'risk' or the presenting problems of young people in their care. Arguably, insufficient attention was given to these challenges, which were repeatedly highlighted by residential workers over the years.

This situation escalated to the point that in order to secure a young person's safety, applications were made to the High Court as a means of accessing placements. The High Court observed that Health Boards could not detain a young person for their own care and protection under the legislative provisions of the Childcare Act 1991 and therefore had to fill this legislative void (Carr 2007). With limited options available to the High Court, non-offending children were being routinely detained under court orders in Children Detention Schools, police stations, hotels, adult prisons, adult psychiatric hospitals and care institutions outside the state (Seymour 2006).

This response placed the Irish state in violation of its obligations under both domestic and international law and attracted much media attention and widespread criticism. However, it was the government's inaction that provoked much critical commentary from the judicial system. The state's lack of accountability to young people and families was the source of much criticism. The High Court repeatedly castigated the state for its failure to protect the constitutional rights of young people who came before the court (Whyte 2002). Commenting on the Health Board's delay in providing secure accommodation, Justice Peter Kelly, in particular, gained national prominence for his criticisms of the system.

While these observations and concerns, cloaked in the discourse of risk, cast another shadow over the residential child care sector, revealing gaps in service provision, positive developments did emerge in the form of the establishment of special care and high support units. In general, the young people who came before the courts had been known to the Health Boards for several years. For some of these young people their histories highlighted a series of failed care placements, missed opportunities for professional interventions, and multi-disciplinary contact with families that had spanned a number of years. The extension and specialisation of the residential system to include high support and special care provoked much discussion and debate, with some favouring the development of a specialist

resource and others querying the effectiveness of secure care in meeting the needs of young people and criticising the failure of the state to provide appropriate services and facilities to children with severe behavioural problems.

As a result, and in a context in which Ireland, from the mid-1990s onwards, was experiencing sudden economic success (the 'Celtic Tiger'), various layers of accountability, managerialism and bureaucracy in residential childcare and in the form of policy and practice initiatives began to emerge. *Delivering Better Government* (DoHC 1996) outlined the government's commitment to providing services that were accountable and transparent. There was a political view circulating that services would be more effective if managed like the private sector (Harvey 2011). Consequently, one of the central mechanisms of the Strategic Management Initiative (SMI) was the devolution of accountability and responsibility from the centre to executive agencies. The aim was to improve financial accountability and new systems obliged Health Boards to produce an annual service plan as well as to secure the 'most beneficial, effective and efficient use of resources' (DoHC 1996: 26).

At this time there were concerns about the number of social workers 'leaving at an alarming rate due to high levels of stress and lack of appreciation of their role' (McGrath 2000: 3). There was a sense that the budgetary framework was the primary focus of the accountability mechanisms in service management (O'Toole 2009). There were further calls for greater accountability and managerialism following the publication of the first major child abuse inquiry in Ireland, the Kilkenny Incest Investigation (McGuinness 1993). The report revealed the inadequacy of the Irish child protection system (Ferguson 1993) and has been described as catalyst for significant reform (Buckley & Nolan 2013). The report significantly changed the context in which policy and practice developed (Ferguson 1993). This report centred on a case of incest in which a young woman had been abused by her father over a 16-year period, during which time the Health Board had continued to be in regular contact with the family. In addition to expediting the implementation of the Childcare Act 1991, the report recommended the recognition of the rights of the child and the primacy of prevention and it called for constitutional reform so that the rights of the child were foregrounded and not subsumed within the marital family. This led to the subsequent constitutional amendment in 2012.

Three years later the first inquiry into residential care practice was published amidst legal discussions, with sections of the report omitted. This inquiry was established by the Sisters of Charity with the assistance of the Department of Health to review the operation of Madonna House, a residential centre in Dublin, in response to allegations of misconduct made against certain members of staff. It was suggested that 'this report had brought residential care to its knees and to the forefront of the public domain' (Dolan 1995:11), leaving a number of care workers from Madonna House 'under a cloud of suspicion by association' (O'Sullivan 2009). Then in 1999 an inquiry was called into Newtown House (SSI 2001), a residential centre that offered a high level of support in a secure setting, after a 16-year-old resident who had been absent without leave was subsequently found dead from a drug overdose. The report noted that there was a small number of trained staff, with high levels of sick leave due to stress and assaults, and a notable absence of professional supervision. The report concluded that staff were 'working in an atmosphere of stress, fatigue and crises without adequate supports to guide their work' (SSI 2001: 89).

As the impact of these reports was being processed, revelations of the ill-treatment and abuse suffered by children between the 1930s and 1970s in the reformatory and industrial schools system were highlighted in a three-part television documentary entitled *States of Fear*. Smith (2001: 23) describes how Raftery's documentaries 'excavated Ireland's architecture of containment by focusing on the very people the structure was erected to deny'. Practices associated with the institutionalisation of children were now being exposed and the historical journey was being viewed through a different lens. It was inevitable that the *States of Fear* documentary, coupled with the Madonna House and Newtown House inquiries would create a sense of mistrust amongst the public regarding residential childcare provision.

The public were now more finely attuned to the sense that children were constantly in danger and as a result policies and guidelines were developed to reduce risk (Walsh 2013). The foundations, such as the introduction of the Child Abuse Guidelines in 1987, had been laid over the previous period (1970-1980) for a professional system to respond to child abuse in the 1990s (Buckley & O'Nolan 2013). In 1999 the Children First Guidelines were published, but the application of these guidelines provoked much critical commentary, primarily due to a failure to impose them on a statutory basis, thus leading to inconsistency in their application (OMCYA 2008; Shannon 2009).

Crisis and Change – 2000 to the Present

By the year 2000, the conceptualisation of the child as a 'rights bearer' had gained much impetus and was articulated with the publication of the National Children's Strategy (2000). This positive development marked a focus on rights-based language in policy development.

The National Children's Strategy recommended an approach based on an ecological system practice orientation. In 2003, the first Ombudsman for Children, whose overall statutory mandate is to promote and monitor the rights and welfare of children, was appointed, and in 2005 of the Office of the Minister for Children (OMC) was established.

In this era, the Children Act 2001 was enacted, underpinned by the principle that detention should only be used as a last resort and that the focus should be on preventing criminal behaviour (O'Sullivan 2000). However, contradictions to the family support rhetoric were evident in the basic philosophy underpinning the Act that parents must be made responsible for the offences of their children (O'Sullivan 2000).

In general, the Children Act 2001 was viewed as a positive development, informed by the principle that detention should only be used as a last resort. The implications of increasing the age of criminal responsibility from 7 to 12 (subsequently amended to create two ages of criminal responsibility – 10 for most serious offences (murder, rape) and 12 for all others), meant that the Health Boards had responsibility for all children aged under 12 who came to the attention of the Gardaí. Practice was now located in the broader context of family support, and the importance of supporting families was a consistent theme in policy and reports, including the Agenda for Children's Services (OMC 2007) . Arguably, the view that children's welfare was generally best secured within the family setting was further consolidated by the public's mistrust of residential care provision as a result of highly publicised inquiry reports.

In 2008, as a decade of prosperity ended abruptly, the government introduced a series of austerity budgets, which impacted on vulnerable Celtic Tiger populations (O'Toole 2009). This coincided with the Report of the Task Force on the Public Services, which recommended that publicly funded services needed to operate more efficiently and effectively, with more attention given to performance and delivery. Following a ten-year inquiry, the final report of the Commission to Inquire into Child Abuse, commonly known as the Ryan Report, was published on 20 May 2009. The report contains harrowing accounts of the lives of children in institutions and details incidences of neglect and abuse – physical, sexual and emotional. Findings indicated that a climate of fear, created by pervasive, excessive and arbitrary punishment, permeated most of the institutions (CICA 2009).

The Ryan Report received international attention. The revelations of the nature and scale of abuse was particularly distressing; however, the cover-up by Church and state increased public indignation and provoked much critical commentary (Ferguson 2007, Stein 2008, Lee 2009, Ferriter 2010, Keenan 2011). The view that 'children in care were from a lower strata and therefore unequal and less deserving' (Lee 2009: 45) was evident in the commission's quest to uncover the truth. It was often reliant on the efforts of survivors of child abuse and advocates to support it in the process.

The same year the government introduced the Ryan Report Implementation Plan (DoHC 2009), to which it allocated a budget of €15m. This positive development was quickly overshadowed by debates regarding the exact number of cases of children who had died in the care of the state between 2000 and 2010 being played out in the media.

TASK 3

Read the following article by Noel Howard: 'The Ryan Report (2009): A practitioner's perspective on implications for residential child care', Irish Journal of Applied Social Studies 12(1), available at: http://arrow.dit.ie/ijass/vol12/iss1/4

The Report of the Independent Child Death Review Group (Shannon & Gibbons 2012) highlighted the deaths of children in care and identified missed opportunities where interventions, if available, could have made a difference to outcomes for young persons. They noted the most concerning finding from a public point of view when they concluded 'that the majority of the children who are the subject of this review did not receive an adequate child protection service' (Shannon & Gibbons 2012: 4).

In 2010, findings from the inquiry into the Roscommon case (Gibbons 2010) highlighted systemic failures that had been identified in earlier inquiry reports. Despite the endorsement since the 1990s of seeking the view of the child in all welfare policies and guidelines, the inquiry report (Gibbons 2010: 69) noted that the voice of the child in Roscommon case was 'virtually silent'.

It is argued that these recent reports highlight the inadequacy of statutory services and demonstrate the continuities between historical practices and current responses to children in need. It was the impact of the successive inquiry reports, coupled with increasing calls from various groups (Constitution Review Group 1996, Children's Rights Alliance 1997) advocating for the constitutionalisation of children's rights, that eventually led to a referendum to insert a clause in the Constitution dealing with children's rights.

Following an audit of existing aftercare services and consultations, the HSE introduced a national policy on leaving and aftercare services (HSE 2011). To ensure a co-ordinated approach in the delivery of services under the Childcare Act (1991) and the Children Act (2001) and in line with international developments, there was a concerted effort to involve young people in processes and procedures on decisions affecting their lives, coupled with support from advocacy groups such as Empowering Young People in Care.

The Ryan Report Implementation Plan (2009) stated that lines of responsibility and accountability for services delivered to children at risk were unclear, evidenced by the fact that there is no national out-of-hours social work service for children at risk or for children in care or their families. In 2011, there was a 50% cut in HSE staff training, despite the increase in caseloads and complex cases (Burns & MacCarthy 2012). At this time, the management structure of child protection and welfare services had been a source of consistent criticism.

Commentaries highlighted the dichotomy between 'protection' and 'welfare' and between 'welfare' and 'justice' (Smith 2005), which had been a recurrent concern in the literature. In addition to this orientation in practice, there were worryingly high thresholds for admission to the child protection system (Shannon & Gibbons 2012), which often delayed the provision of care for young people who needed it. Failures of multi-disciplinary communications (Duggan & Corrigan 2009) and increasing workloads were making it more difficult to engage with children in care (Lynch & Burns 2012).

In this context, change was eventually proposed in 2012 when a task force was established to advise on the preparations for the establishment of a child and family support agency on a statutory basis (DCYA 2012). Tulsa, the Child and Family Agency, is now the dedicated state agency responsible for improving wellbeing and outcomes for children.

Challenges continue to exist at the coalface of practice, with greater scrutiny, accountability for service delivery, and fear of ligation shaping the way services are delivered (Buckley & O'Sullivan 2007). These developments have led to a stronger emphasis on policies relating to accountability and performance. Accountability was further consolidated in 2012 with the publication of HIQA standards for statutory child protection social work departments. HIQA's remit was now extended to the inspection of family and childcare services and to the development of standards.

This chapter concludes that despite efforts to rectify historical deficits, and despite positive developments in that direction, challenges remain. A common theme emerges that is a clear constant across each period of our history: the government's attitude. This attitude is manifested in piecemeal reform, inaction and reactive responses to inquiry reports/controversies, which leads to policies being developed in times of crisis with fragmented solutions. Challenges articulated by advocacy groups, social care workers and cumulative committee recommendations have received limited attention. Consequently, knowledge has not been accumulated and there have been limited responses to challenges as they presented. There is clear evidence that demonstrates social care workers' concern around the inadequacies of the system; however, it appears that change only occurs when situations are at crisis point or when there is a threat of litigation. Despite the evidence of discursive shift and consequent changes in service provision, gaps are still evident. One notable absence in the development of social care provision is the voice of the social care worker. The culture of accountability, although welcome, needs to be monitored in relation to its impact on day-to-day practice. The legal and risk management responsibilities of child welfare systems have shaped the overall orientation of our social care sector, this is an area that warrants attention in terms of the impact on relationship-based practice.

We need to continue to highlight gaps in service provision and endeavour to be part of a collective voice for social care reform. We must, however, remember that there are parts of our history we can be proud of; we need to learn from the important continuities of best practice and expertise built up over decades and recognise the commitment and dedication of past social care workers. To ensure the next chapter in our social care history is one to be proud of, we suggest the following areas need to be addressed.

Moving Forward to the Future of Social Care	
1	There is a need for the voice and experience of service users to be visible in policy formation and service delivery. These voices need to be not only heard but encouraged and fostered.
2	Although the legal and risk management responsibilities of child welfare systems shape the overall orientation of our social care sector, we need to ensure that organisational structures and culture facilitate, rather than impede, positive outcomes for service users.
3	Social care education and practice need to focus on the structural and institutional nature of oppression.

Tips for Practice Educators

- Discuss with the student the historical development of your agency. Set a task that supports the student in identifying the wider socio-economic and cultural contexts of social care practice.
- Support the student in documenting their views and understanding of social care history in their reflective diaries.

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Chapter 76 – Niamh Delany

Domain 5 Standard of Proficiency 15

Recognise the role of advocacy in promoting the needs and interests of service users, and understand the influence of system-level change to improve outcomes, access to care, and delivery of services, particularly for marginalised groups.

KEY TERMS

Advocacy

Needs and interests of service users

System-level change

Outcomes

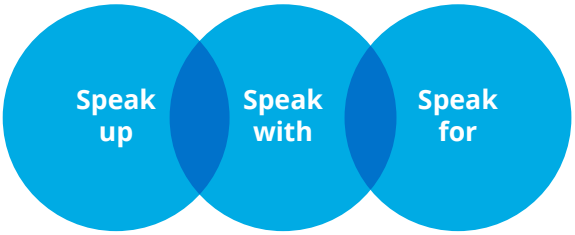
Social Care is … respecting, listening and building relationships. From those foundations a path can always be found. The pace of progress is different for everyone; sometimes you need to go backwards to ensure that the person is still with you in the relationship.

TASK 1

Describe a time in your life when somebody helped you to speak up for yourself or spoke up for you. How did it feel? Did you learn and grow from this experience? Did you feel that you could have been a bigger part of the process?

Advocacy

Advocacy is an inseparable part of the fabric of our daily working lives. Supporting service users to access and realise their rights is often a large part of the job description. We advocate to meet the needs of individual service users and for system changes when they are needed to improve the outcomes for both individuals and groups. Advocacy, when practised effectively, enables somebody to speak up for themselves through increased education and accessible communication tools. It can also mean speaking with a person, for example attending a meeting with them and providing support or advice if required. Even when a social care worker needs to speak for and on behalf of a service user to effectively advocate for them, any actions should be based on the service user's needs, interests, will and preferences.



'Advocacy can be a difficult concept to grasp … Some people only equate it with legal representation … Some believe it is simply about speaking up and out, on behalf of oneself and others. Advocacy is all of these things, but it is more. It is about a process; how one speaks or represents another, whether the principle person is involved, how people are involved, and the accountability we have to those we represent' (Birmingham 2001:4).

There are four different types of advocacy: self-advocacy; representative advocacy; peer advocacy; and group advocacy. Each type includes the values of **independence**, **autonomy**, **empowerment**, **equality** and **citizen engagement**. Advocacy occurs in all social care settings and the type of advocacy will be determined by the underpinning values of both advocacy and social care.

Independence: The concept of independence in relation to the type of day-to-day advocacy that social care workers provide will almost always feature some level of tension between those on whose behalf they are advocating and external forces, including access to funding, legislation and policies (Drage 2013). Social care workers are rarely independent in relation to the funding systems they work within. However, the commitment to advocacy, social justice and equality as the founding values of their profession means that social care workers are duty bound to advocate against social injustice and inequality.

Autonomy: This can be described as self-directed decision-making. When working as an advocate in social care work, we must remain faithful to the autonomy of the person/people we are working with. How are they directing this advocacy process? Have we checked in with them at every stage of this process? How can we empower the person throughout this process? Some people may need support in relation to equal legal recognition of their autonomy.

Equality: It is part of a social care worker's duty to establish what, if any, extra support is needed in order for equality to be realised. Equality and social justice are inextricably linked. Our primary role in relation to equality in social care settings involves ensuring that the people we work with can realise their human rights on an equal basis with their peers. Some people do not have access to adequate employment support due to a lack of accessible communication. Some residential settings may have 'one size fits all' policies, perhaps with regard to individual finances or visiting rules. This may not respect the value of equality. Our work in relation to equality begins with identifying systemic barriers to equality. The Irish Human Rights and Equality Commission website (www.ihrec.ie) provides information on human rights and equality.

Citizenship: Social conditions can lead people to be proactive and engaged or passive and alienated (Ryan & Deci 2000). Effective advocacy promotes the development of active citizenship. In order to promote active citizenship, social care workers may engage in supporting and facilitating self-advocacy groups; individual self-advocacy; and peer-based advocacy groups. In residential services, regular 'house meetings' are often facilitated in order to allow service users to give feedback in relation to the service provided.

TASK 2

Discuss the following question.

Are service users encouraged and supported to engage in the democratic process? Is voting information accessible?

Policy and Legislative Background

The code of ethics and conduct provided by Social Care Ireland describes the primary goal of social care work as 'advocating for and with, supporting, enabling and empowering individuals, families and groups'. The values underpinning the code of ethics are described as 'respect for dignity, the promotion of social justice and equality, honesty and integrity, and the recognition that human potential is most often realised within the interplay between the independence and interdependency' (SCI 2021). CORU's code of ethics and conduct for social care workers also refers to the responsibility to advocate for social justice under Section 31 of the Health and Social Care Professionals Act 2005 (SCWRB 2019).

The Jigsaw of Advocacy policy document was published in 2003. It describes advocacy as 'the key which will unlock entitlement to services for those who are often bewildered by the bureaucratic complexity of access to social and other state services' (Weafer 2003: 4). Our domestic legislation refers to advocacy in the Citizens Information Act 2007. Social care workers will often incorporate these supports into their day-to-day working life. The National Advocacy Service (NAS), established in 2011 by the Citizens Information Act 2007, provides issue-based representative advocacy to marginalised groups, particularly people with disabilities. A referral to NAS services can be made by or on behalf of anyone fearful that they are not receiving services on an equal basis with others or are being denied their rights. Often social care workers will facilitate advocacy in relation to these issues and, if necessary, escalate a referral to NAS. This is a nationwide service with regional offices. More information about NAS and making a referral can be found at https://advocacy.ie/.

Autonomy, Person-centred Planning and Assisted Decision-making

The people we work with often need support in recognition of their decisions. This is particularly relevant to those with an intellectual disability, psychosocial disability or different communication needs. One of the most significant changes in relation to social care work practice in this area is the principle of respecting the will and preference of the person, which replaced the 'acting in the best interests' approach. This means that we now act on the evidence of what choices people want to make. We do not assume that we know what will be best for the person. Social care workers, with our relationship-led approach, are uniquely placed to effectively explore, discover and document the will and preference of the people we work with.

Recognition of legal capacity has traditionally worked on the premise that the self-contained person will make reasoned decisions to protect his own interests. Where someone was not considered capable of reason, they were considered no longer equal in the eyes of the law. The poet John Donne wrote, 'No man is an island entire of itself; every man is a piece of the continent, a part of the main.' Relational autonomy is an approach that takes account of the different social systems and supports that influence decision-making.

Article 12 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), is concerned with equal recognition before the law. In a commentary on Article 12 of the UNCRPD, Arstein-Kerslake and Flynn state that this Article has been identified as the catalyst for change in this area (Arstein-Kerslake & Flynn 2016). A focus on providing appropriate support rather than placing the onus of change on people with disability is consistent with the social model of disability, a key driver of the UNCRPD.

Ireland is poised to implement an Act loosely based on relational autonomy theory. This Act came about as Ireland was preparing the groundwork for ratification of the UNCRPD. We have, as Moira Jenkins explains, entered a 'new ecology for the exercise of rights' (2018). She was referring to the new legal framework around decision-making in Ireland. The Assisted Decision-Making Capacity Act 2015

is a phenomenally important piece of legislation for the exercise of autonomy for people who struggle to be recognised as equal in the eyes of the law, such as people who have an intellectual disability or psychosocial disability.

Jo-Anne Watson, an academic in Australia, completed research in 2016 on the role that frontline support workers can play in recognising decision-making capacity through facilitating person-centred planning when providing support to people with very complex communication needs (Watson 2016). Her empirical study of five people with severe or profound intellectual disability provides an insight into what supported decision-making through person-centred planning can look like. It also highlights the effect of supporters having positive assumptions of decision-making capacity as a factor in supported decision-making. The study aims to influence practice and policy efforts to ensure that people with severe or profound cognitive disability receive appropriate support in decision-making.

Social care workers often practise the support of relational autonomy in their working day. 'Through hanging in and hanging out social care workers learn the likes, dislikes and needs of the service user' (Lyons 2017: 89). They may participate in an organisational person-centred planning programme. Many of these programmes exist; however, it is the relationship between the social care worker and the person they are planning with that determines the quality of the plan. If the plan is documented and progressed in a meaningful way, it can assist people in realising the right to autonomy and equal recognition before the law. These programmes can be used to establish will and preference in relation to finances, medical support, services offered, places to live and much more.

A Decision Support Service (DSS) is planned to assist in promoting the rights and interests of people who may need support with decision-making. The DSS is not operational yet. There is a plan to commence the service in mid-2022. Information on this service can be found at www.decisionsupportservice.ie.

Advocacy in Practice

The examples included here are an amalgamation of events experienced over the course of sixteen years of social care work in intellectual disability services. No example represents an actual event.

Case Study 1

Local level self-advocacy made effective through appropriate systems.

Tom, Brosna and Jack live in a residential house run by an intellectual disability service. They have a house meeting every week. Everyone must be there for the meeting to go ahead. Two staff members must be there too, and everything that is said is written down. Last week Brosna and Jack said that they were disappointed that they could not bring their friend on a daytrip with them even though there was room on the bus. This was because their friend has epilepsy and the staff in their house are not trained to give him his medicine. When the social care leader read the minutes, she put in a request for the team to receive training for administering medication to Jack and Brosna's friend. This will happen in two months' time, when their friend's team will also be receiving training. Jack and Brosna are told that in the summer they will be able to organise daytrips with their friend.

Case Study 2

Engaging in or identifying opportunities for equality and human rights training/education and training/education on the democratic process for the people we work with.

Marian has been an advocate for the people who share services with her for many years. Her social care worker key worker has identified a class in the community on equality and rights. Marian is looking forward to learning more about 'standing up' for herself and others.

Case Study 3

Identify opportunities for stakeholder involvement in consultations.

The government is looking for people who have lived experience of intellectual disability services to participate in a consultation group. Yetunde is a social care worker working in the area. She reads about it on social media and encourages Aoife to apply. Aoife is passionate about improving the services that she and her peers receive. She wants a job, but she needs someone to help her. The HSE has recently cut employment support funding because it says it is not its role to support employment. When Aoife went to the new employment support service, they didn't know how to talk to her, never mind help get her a job! Yetunde requests that she is on shift on the day of the consultation. She reads through the information with Aoife and helps her to prepare what she would like to say. They research the bus route together. On the day Yetunde politely asks the chair to give Aoife a little more time to speak as she can see that Aoife has more to say.

Case Study 4

Collect data on rights realisation within the area they are working in.

Claire works in a large day service for people with intellectual disabilities. She is passionate about rights realisation for people with disabilities. Claire develops a rights checklist and asks people using the service if they would like to fill it out with her. When the checklists are filled out, Claire establishes that 85% of the 50 people using the service have not chosen where they live; 65% of the people using the service want a job but have no access to employment supports; and 70% of people using the service have no respite support. When a local politician calls to the service in the run-up to a local election the self-advocates use these statistics to guide their conversation.

Being an Advocate

Social care work is a focus on individual relationships. We work with service users and discover what system change can help them. We build relationships with the people we support through the 'doing' (Lyons 2017: 307) of shared experiences, 'hanging out and hanging in' (Garfat & Fulcher 2011). The relationships that are built during this work enable empowerment and advocacy. Unlike other allied health care professionals, social care workers do not learn how to master our craft in one fell swoop. Our job changes with every individual and set of circumstances we meet. It is shaped by the relationship with the person who is being supported and their desires and needs. We master ourselves; we channel our skills, listen, adapt and empower. The outcomes achieved by people we work with are not our professional victories; they are the victories of a service user empowered to overcome barriers and achieve meaningful outcomes.

Social care workers need to think on their feet every day in order to react appropriately (Lyons 2017: 288, 387). Some days we will arrive at work to find the atmosphere chilled out and benign. We will adjust our energy to complement this atmosphere and will find opportunities to progress advocacy for desired outcomes and to develop the relationship. On other days we will need to use the relationship to ask the person to trust us enough to remain calm. Advocacy is an integral part of the everyday work of social care workers. Advocating through relationships and empowerment results in meaningful outcomes for the people we support. We may use the relationship to realise the function of a behaviour and in partnership with the person advocate change in the systems in place to support them.

TASK 3

Please read Claire Leonard's chapter 'Supporting a Team to Direct and Lead Change in Social Care' (see References) as an example of how a system-level change was successfully introduced to change a sheltered occupation service into a training and activation service.

System-level Change

As well as recognising the role of advocacy in promoting the needs and interests of service users, this proficiency acknowledges the importance of understanding how system-level changes in your social care service can also improve outcomes, including access to care delivery, especially for marginalised groups. According to the World Health Organisation (WHO 2017), 'people with disabilities are among the most marginalised groups in the world'. System change is the introduction of new practices or structure which are aimed to improve the performance of the service (Birney 2015). This proficiency draws our attention to the importance of change within organisations and how, if managed correctly, it can have a positive impact on outcomes for service users. According to Burnes (2004), organisation change is influenced by both internal or external forces. Leonard (2014) provides an example of how her organisation implemented the New Directions Policy (external force) to change a 'sheltered occupation service' into a 'training and activation service'.

One example of an internally motivated change is based on my own experience. I worked on a Self Advocate and Family Forum in my service, which lobbied the management for a system-level change that would make easy-read appointment letters the norm for correspondence given to service users. This system-level change was driven by the need to empower service users to have easy access to information that was relevant to their care. Making system-level changes can be difficult, especially if the change has an impact on the culture and practice norms of the organisation. Leonard (2014) demonstrates that giving staff time, having lots of meetings focused on the proposed change and the possible impact on each individual, and providing training when needed, helped with the introduction of new practices. This chapter concludes with some tips for practice educators on how to help students understand the important role of advocacy in social care practice.

Tips for Practice Educators

Practice educators could consider how they might enable the student to build an awareness of how the values of advocacy can guide system-level change. Through focusing on the needs and interests of service users, students will find a path to flexing their advocacy muscles. The following reflections may be useful to encourage a more robust understanding of the values.

Reflection in relation to independence for the student on placement:

- What are the power structures in the organisation?
- How would I voice concerns?
- What is the funding structure for the organisation? An organisation that receives funding for providing a rights-based service will have a vested interest in making advocacy for human rights a priority.

Reflection in relation to autonomy:

- Can I further empower and promote autonomy within this placement?
- Can everyone communicate effectively and are communication tools consistently used?

Reflection in relation to equality:

- Can the person I work with exercise their rights on an equal basis with their peers?
- If not, what supports do they need?
- What barriers are present?

Reflection in relation to citizenship:

- If there are house meetings, do they work for the residents; can the residents put forward their own agenda?
- Have the house meetings been effective in changing practice in the service in accordance with issues identified?
- Are feedback mechanisms such as complaints policies in place, accessible and advertised?

Practice educators could encourage students to complete these reflections in relation to their placements. Even the smallest issue will require deep reflection. Often students have fresh eyes and can critically evaluate practice in a way that can have a lasting positive effect on the service.

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Chapter 77 – Denise Lyons

Domain 5 Standard of Proficiency 16

Understand the role of, and be able to demonstrate skills in the use of creative and recreational interventions in social care work to meet the needs of the service user in a variety of contexts.

KEY TERMS

Defining recreation

Defining creativity

Recreation and creativity as interventions in social care practice

Social care is … planned practice. In the day-to-day lived experience of practice, social care work appears 'in the moment'. However, the worker's response is a planned approach to meet needs, uphold rights and enhance the potential for meaningful and creative shared experiences.

Despite the importance of creative and recreational interventions in social care practice, there is only one standard of proficiency that references the terms 'creativity' and 'recreation'. Chapter 72, which describes 'activity' as opportunities for meaning-making, increased participation and engagement, should be read in conjunction with this chapter. 'Intervention(s)' are discussed widely: as requiring consent (Chapter 15); as part of the care plan developed in partnership with the service user (Chapter 35), which needs to be evaluated and revised (Chapter 48) in terms of risk (Chapter 50). These key terms are addressed here in this chapter, but also included is a discussion of the importance for the student of engaging in creative and recreational activities during their formal training, as well as the benefits for the service user, which are broader than identifying needs. This proficiency requires an understanding of the role of creativity and recreation as an intervention within social care to meet needs in a variety of contexts, and also requires that the student be able to demonstrate skills in using these interventions. This is a challenging task; therefore, I have drawn on the expertise and knowledge of my colleagues in the Creativity and Innovation in Social Care (CISC) network to support this discussion (Jackson 2021; Mac Giolla Rí 2020).

Defining Recreation

Recreation is a term used to define the active participation in variety of pursuits for fun, education, socialising, exercise and sport (Kraus 1998; Benatuil 2018; Rodriguez de la Vega & Toscano 2018). Recreational activities are 'undertaken by choice during free time, with the aim of experiencing the pleasure derived from the activity itself and finding in it intimate satisfaction and an opportunity for recreation' (Benatuil 2018: 52). Recreation is deemed separate from leisure, which is viewed as a passive experience during your free time (Klaus 1998). Benatuil (2018: 53) states that although both leisure and recreation relate to pleasure and enjoyment, they are distinct in the following ways:

Recreation	Leisure
Organised and directed activities.	Entertainment-related activities.
Planned – can be engaged in as an individual or a group.	**Random** – can be engaged in as an individual or a group.
Active – associated with participation and engagement with a planned activity.	**Passive** – associated with free time and relaxation.
Emphasis on doing, outcomes or challenges and goals.	Little or no emphasis on doing challenges.

People choose to engage in recreational activities to enhance their creativity and as an outlet for their personal expression and interest (Klaus 1998; Benatuil 2018). The types of recreational activities used as interventions in social care settings are physical (sport activities, including the Special Olympics, active games, fitness and exercise classes, swimming and walking), social (participation in non-sporting clubs and societies, parties and trips out as a group) and creative (art, drama, singing and music) to name a few. Engaging in recreational activities enables service users to become active participants in their community, to become healthier, to maintain friendships, have fun, increase their overall wellbeing and exercise choice.

TASK 1

Read Chapter 72 and create examples of recreational interventions that involve the head (planned practice to meet needs), the heart (relationship development) and the hands (doing with others – community engagement).

Defining Creativity

Creativity is defined by Benatuil (2018) as a form of recreation and by Mac Giolla Rí (2020: 86) as 'an ordinary human ability' that can be experienced and practised by all. Understanding creativity includes a knowledge of the theoretical perspectives that underpin creative practice. Kaufman and Beghetto (2009) make a distinction between big 'C' creativity, or the activities we associate with professional artists, musicians and thespians, and little 'c', which includes the everyday creative pursuits of planting a garden, decorating a cake, or styling your external identity through your clothes or hair colour. The perception that big C creativity is only experienced by individuals with an enhanced ability or talent has been challenged (Runco 2007). Over time, with prolonged engagement in the creative activity, and a little luck (Runco 2014), ordinary people can explore new ideas (Boden 2009) and ways of working and self-expression to create at a big C level. For Runco, everyday creativity involves the same processes as big C: '*after the creative idea is produced, expertise may add to it, persistence may allow a refinement of it, impression management may couch it so it is accepted, and so on, but the creative part of the process (e.g., the construction of an original interpretation of experience) is the same as the creativity of little c creativity*' (2014: 132). Thus, creativity is not defined by an outcome or product that is deemed of value; it is about the dynamic process and the changes or benefits experienced from engaging in the creative act (Walia 2019). Runco (2007) redefined creativity as a hierarchical framework, building on his original theory of the 4 Ps (person, product, process and place). This framework makes a distinction between ***creative potential*** (person = your personality, process = cognitive and social, place = access and environment) and ***creative performance*** (products of creativity). Here creativity is affected by the individual, their ideas and motivation, and the external environment. This theory is relevant to social care work as the environment, including the service and the staff members, has a role to play in the service user's ability to engage in creativity.

TASK 2

Understanding Creativity

For a greater understanding of creativity, read the journal article by Denise Mac Giolla Rí (2020), 'Learning to put everyday creativity, semiotics and critical visual, semiotics and critical visual literacy using inquiry graphics (IG) visual analysis to work in social care' in the *Irish Journal of Applied Social Studies*, Vol. 20, Issue 2, available at https://arrow.tudublin.ie/ijass/vol20/iss2/.

TASK 3

Questions about Your Creativity

How do you express your creativity? Do you define yourself as a creative person? If yes, in what way? What are your fears around engaging in creative activities during your studies or practice?

Interventions in Social Care Practice

Evident from the multiple workplaces of the chapter authors in this text, social care is practised in a variety of different settings, with a shared aim; to provide care and support for children or adults. Irrespective of the setting, social care workers are directly involved with people, using assessment and planned interventions to provide for the holistic needs of diverse and vulnerable populations (Lalor & Share 2013). The Standards of Proficiency for Social Care Workers (SCWRB 2017) state that interventions are only provided when consent is granted and documented (D1 SOP 15 – see Chapter 15) and are created in partnership with the service user and his or her family, when appropriate (D2 SOP 12 – see Chapter 35). SCWRB (2017) also references the importance of reviewing the intervention based on the service user's feedback and of ensuring that this is documented and included in all future plans (D3 SOP 8 – see Chapter 49). Students become familiar with the term 'intervention' from their placement portfolio, used as an opportunity for students to demonstrate initiative and planned practice and integrated knowledge (IASCE 2009). Students, under the supervision of their practice educator, and with consent from and in collaboration with the service user, plan an intervention to meet the needs of service users, and demonstrate the practical skills learned through creative studies modules (Graham & Megarry 2003). The creative studies text *Creative Studies for the Caring Professions* (Lyons 2010) includes multiple creative interventions (in each chapter and in the appendix) that can be adapted and used with service users from a variety of social care settings. Facilitating creative and recreational interventions with service users enables you, the worker, to have an active role in their engagement in creativity and an opportunity to demonstrate your skills. Creative and recreational interventions have multiple roles in social care practice and education, which include, but are not limited to, social development, increased cognitive engagement, fun, relaxation, self-expression, movement, imagination, promoting resilience, freedom, choice and meaning-making (Lyons 2010; Mac Giolla Rí 2010, 2020), and this chapter focuses on the following roles: relationship development; to meet needs; for community engagement; and for self-awareness and facilitation skill development.

Relationship Development

Social care work is experienced through the relationship between the worker and the service user and engaging in recreational and creative activities can facilitate this process. Creativity in practice is reliant on your ability as a social care worker to facilitate a psychologically and physically safe space for personal expression and play. This begins with the relationship between you and the service user, inspired by your own courage to take risks, by being less self-conscious of your image-making or creative expression. This process starts with the relationship as you learn the likes and dislikes of your service user(s) and the types of activities they may be interested in.

One example of how creativity in social care education can support the relationship development of students and service users is evident in a joint initiative between the Daughters of Charity Disability Support Services and TU Dublin Blanchardstown Campus that began in 2009. 'Learners', adults with an intellectual disability from the daughters of Charity Service, became full-time students in the creative studies module on the social care programme in TU Dublin. As well as studying in the classroom together and developing relationships as student peers, this project provided opportunities for people with an intellectual disability to actively participate in the college community. This also created an informal space for social care students to learn the fundamentals of how to communicate and develop relationships with people with diverse needs. As the lecturer, I noticed how the 'learners', through their creative freedom of self-expression, encouraged the social care students to play, have fun and fully engage in the creative activities. Relationships formed naturally and social care students became both learner and teacher as they sat together doing the shared activities. (Photographs of the learners engaged in the shared creative activities are included here with permission.)

To Meet Needs

Meeting the needs of service users is a core threshold in the Standards of Proficiency for Social Care Workers (SCWRB 2017). Students must demonstrate that they *'understand the role and impact of effective interdisciplinary team working'* in meeting needs (Chapter 37), *'gather all appropriate background information relevant'* to the service user's needs (Chapter 41), *'demonstrate an evidence-informed approach'* and adapt practice to meet needs (Chapter 46), *'identify and document ... unmet needs'* (Chapter 55), *'demonstrate safe and effective implementation of a range of practical, technical and professional practice skills relating to ... specific needs'* (Chapter 73) and *'recognise the role of advocacy in promoting needs'* (Chapter 76). The Freda principles of fairness, respect, equity, dignity and autonomy (HIQA 2019) is an excellent framework to support the application of creative and recreational activities to meet needs in a human rights-based approach to practice.

Principle	Role of Creative and Recreational Interventions
Fairness	Listen to the service user and seek out their likes and dislikes. Ensure that they have all the information needed to make a decision on what intervention they would like to engage in. Receive consent before beginning your creative or recreational intervention.
Respect	Spend time with the service user before engaging in creative or recreational activities with them. Work at their pace and be courteous in your manner and how you communicate. Listen without judgement and respect their likes, dislikes and interests.
Equity	Support your service user to have equal opportunities and to fully engage in activities of their choosing. You may need to adapt the intervention to ensure that people of mixed ability can engage fully in the intervention. Always assume that the service use has the capacity to engage, first, before you exclude an experience or activity from them.
Dignity	You can demonstrate dignity to the service user in the way you communicate the stages of an activity or intervention. Risk assess all interventions to ensure that the service user is not physically or psychologically harmed based on their participation.
Autonomy	Service users express their autonomy in getting to choose the activities and interventions they want to experience. It is important to support the autonomy of the service user to refuse to engage in your intervention or plan.

TASK 4

Apply the FREDA principles to this case study and note the important steps Sharon needs to take to ensure that the intervention applies the principles of fairness, respect, equity, dignity and autonomy.

Case Study 1

The following practice example was shared with me by one of my past students, who is now a social care leader in a residential service for adults with an intellectual disability. Sharon (not her real name) used an activity she had learned in her first-year creative skills module in her work with one service user preparing for his person-centred plan presentation day (PCP day). Paul (not his real name) is non-verbal, so Sharon used the 'clay world' workshop to support Paul to visually express his plan for the coming year. Using clay, Paul carved out his dream of going on holiday, through the shape of a plane, his plan to learn how to travel independently to the day service, evident from his happy face on the bus and the importance of family and friends, illustrated through heart and star shapes. Creating the clay world together enabled Sharon to learn about Paul's desires for his future and the activity produced a tangible object that he could bring to his PCP day to share these ideas with his friends and family. This clay world activity was used to meet Paul's need to communicate using tools that related to his ability, will and preference.

The clay world intervention that Sharon used is available to view on YouTube. The video is a recorded workshop (poorly edited and filmed by myself), but offered as an sample activity for social care students in IT Carlow. The three participants, IT Carlow lecturer Caroline French, jewellery maker Tracey Weir and myself, made three clay tiles to represent our life and interests through clay.

TASK 5

Watch the Clay World Workshop and make your own clay world to represent you and your current needs or desires. The full workshop is available to watch on YouTube (https://youtu.be/mleh3oy89dI) with permission to share granted by the three participants.

Community Engagement

Recreational and creative activities play an important role in increased community participation. Walking around the community and visiting the local amenities, like the post office, library and coffee shop, are planned activities for increased community engagement and social learning (Ross *et al.* 2009; HSE 2012). The New Directions Report (HSE 2012) noted the importance of leaving the centre and getting out into community spaces, becoming members of local recreational clubs and societies and taking part in activities as examples of the normalisation of care (Gilbert 2009). Getting to and from the activity enables the worker to spend quality time with the service user, and use the time to chat and learn more about their interests and potential new hobbies. Ferguson (2009) discussed the importance of the 'car conversations', as being in the car supports open, free conversation and a sharing of stories about the activity experienced.

Case Study 2

Scott (not his real name) is a 30-year-old man with a mild intellectual disability who lives in a community house with three other males, all over 60 years old. Although Scott communicated to staff that he was lonely and wanted to make new friends, he was reluctant to join any of the groups in the local community where he lived. Scott was interested in taking photographs and I asked him would he like to participate in creating a photographic collage made from images of his world and all the people and places he loved. So, with consent from Scott and the support of the team, we began to plan the project, beginning with the purchase of a disposable camera. On one of our 'photographic walks' through the village, Scott stopped to take a shot of the street we had just walked up. He was outside a Men's Shed and one of the participants came out to say hello and asked Scott about the project. Scott was invited to visit the Men's Shed to talk to the other members about his photographic collage. Walking past the Men's Shed became part of the photographic walks and Scott eventually gained the courage to drop in and say hello and chat to the men about what they were making. The photographic project and his meeting the members of the Men's Shed was the beginning of his increased participation in the community.

TASK 6

Think of a new creative or recreational intervention that could support a service user to actively engage in the community.

Read Chapter 72 for more information on community engagement, the use of spaces within the service and the role of car conversations for meaningful moments in your practice.

Self-awareness and Facilitation Skill Development

Engaging in recreational and creative activities with your service user 'fosters hidden potential, growth and actualisation ... encourages playful and imaginative engagement with processes and critical reflection, within a safe space, so new ideas and practices can emerge' (Mac Giolla Rí 2020: 86). Social care workers need to experience creativity to help them to develop empathy, to become sensitive to the emotions of others, to learn how to adapt and change in order to meet the diverse needs of service users (Jackson 2021). Encouraging creativity in others begins with the development of your own skills, which can be based on your own participation in recreational and creative activities, or during the time spent on the creative modules in your formal social care education. Central to creative skill development is the ability to facilitate activities that are strengths-based, timed in a way that reflects the ability and pace of the service user, and based on their choice and interest and/or need.

TASK 7

Understanding Facilitation

For a greater understanding of how to facilitate creative and or recreational activities, read the chapter by Paul Timoney (2010) 'Creative Group Facilitation' in Lyons, D. (ed.), Creative Studies for the Caring Professions

Use the template in that chapter to design a creative activity for your service user.

Creative modules are viewed as an important part of social care education, in part for the development of facilitation and creative skills, but also to offer students experiential creative experiences for their own self-expression, reflection, self-awareness and relationship development (Lyons 2010). Some programmes may include recreational activities as part of the suite of experiences offered to students. Recreational activities may be more accessible to students from their own life experiences outside college, experienced through their membership of sports groups and clubs, and social outings in the community. Therefore, many social care programmes focus on the development of the students' creative and facilitation skills. The creative modules are important for skill development and through practical experience students learn about the different materials and types of activities they can use and adapt to the different people they will encounter in practice. Students do not need any prior knowledge or experience in the arts to actively engage in the workshops and this will help students understand that creativity is for all, irrespective of ability. The classroom becomes a safe space for the student to practise their creative and facilitation skills without the pressure of producing a finished product. The importance of the process, messing with the materials, learning by doing, sharing personal information, being encouraged by others, helps students understand how to create with others. Over time students develop a 'tool-box' of creative activities they can use as interventions in practice.

Practice placement is the space where students experience the value of recreational and creative activities in terms of seeing how engaging in creative activities can enhance relationships, demonstrate facilitation skills and meet needs. Students on placement have more time to spend with service users and creative and recreational activities form an important part of their time together. By applying the FREDA principles (HIQA 2019), students can facilitate activities that meet needs, promote fairness, respect and autonomy and enable service users to be seen in ways that promote their abilities, strengths and capacity. Creativity can also challenge the student's preconceived ideas about the service user by providing opportunities to see them in a new way. My first social care placement in the early 1990s was a sheltered workshop for adults with a physical disability and the following case study is an example of one service user's capacity to engage in creative interventions.

Case Study 3

One day a dance teacher came to the centre to facilitate a workshop with the service users and students on placement. One of the service users, Tom (not his real name), was in an electric wheelchair and I noticed that he was also attending the session. I did not know Tom well at this stage and I wondered how he was going to actively participate in the workshop. Music filled the large hall, and the facilitator told all participants (service users and social care students) to create shapes with their body as they moved in time with the melody. At first, I was very self-conscious of 'dancing' until I noticed that everyone else had become lost in the music and their own movements. Tom started to move his chair in a figure of eight shape, in time with the music. The dance teacher, seeing this, responded to Tom's movements and began to dance with him. At one point, she was sitting on the side of the wheelchair as they moved around the hall creating beautiful shapes as one unit. This was a key learning moment for me, in realising how I had underestimated Tom's ability to actively engage, based on my preconceived and inaccurate ideas about him. In that moment, Tom was not defined by his wheelchair or disability – Tom was a dancer.

TASK 8

Watch the video from 'Gravity' Wheelchair Dance by Marisa Hamamoto and Piotr Iwanicki, available on YouTube: https://www.youtube.com/watch?v=v_JiNAK9dY8

Depending on the setting and the interests and needs of the service user, creative and recreational interventions may form part of the day-to-day lived experience of practice. Social care workers can use activities within practice as opportunities for self-expression, for imagination, to illustrate person-centred plans, and to have fun. It is important for social care workers to ignore the internal critic, lead by example, and play freely with their own creative expression, without fear of producing an end product which will be judged by others as either 'good' or 'bad'. Some settings provide more opportunity to engage in creativity than others, but there are many ways to use recreational and creative interventions to meet the needs of all our service users. The social care worker plays an important role in supporting the service user to engage in activities and this time spent together helps to enhance your relationship as well as provide opportunities to assess and meet needs.

Tips for Practice Educators

Creativity for self-expression – Ask the student to work directly with one service user on a creative activity that is fun and enables the service user to share something about themselves.

Use of materials – Encourage the student to look at past activities completed by the service users and create a new activity using the same materials.

Recreational activities – Ask the student to focus on one service user and though communication and based on their needs, interests and choice, to support them to join a new group or plan a social outing.

FREDA principles – Ask the student to apply the FREDA principles to the creative and/or recreational activities they have planned for placement.

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Chapter 78 – Francis Gahan

Domain 5 Standard of Proficiency 17

Demonstrate ability to participate in or lead clinical, academic or practice-based research.

KEY TERMS

Participate

Lead

Practice-based research

Clinical and academic research

Social care is … a bridge to equality, human-rights, personal fulfilment and happiness. Social care workers form that bridge in the care, support, advocacy and inspiration that they provide. It is on the foundations of a trusting an empowering relationship that the bridge is built.

TASK 1

Consider how social care workers can use research in practice to improve the quality of their work and outcomes for service users

Introduction

The terms 'clinical', 'academic' and even 'practice-based' research might conjure up notions of rigour, procedure, strict protocol and strategy that one may need to adhere to in the pursuit of knowledge or to provide solutions to social problems. And in certain contexts this can be the case: research often strives for objectivity and applies procedures or tests to validate a hypothesis or develop an understanding about a particular issue. As a student setting out on a career in social care, one might easily consider the worlds of 'research' and 'practice' to be two very distinct concepts, each adhering to their own set of rules and following their own protocol. Research might be thought of as something separate from the world of social care and a job that can only be carried out by people who are highly skilled or professionally trained in its application.

However, through the academic and practice experiences of social care training, it becomes possible to apply the principles and philosophies that underpin 'research' both to the research task itself and also to the work that happens in social care. In fact, it could be argued that the social care worker, rather than the academic researcher, is better placed to undertake practice research. This type of research can subsequently influence the standards of practice itself. This can be due to our need for 'intimate' knowledge of the lives of service users and of the processes involved in social care work, allowing the social care worker to apply a more collaborative approach at all stages of the research.

Research and Social Care Education

As part of academic training, students may undertake a 'research methods' module to give them the skills and knowledge required to undertake meaningful research. It can also provide them with a foundation on which to write a final-year or postgraduate research dissertation. This may involve learning about which methodology is appropriate to carry out a research project. They will learn about whether a qualitative or quantitative methodology is the most suitable approach to answer their research question or to test their hypothesis. They will also likely to learn whether their research is best suited to a mixed methods approach. Subsequently, they will learn which method of data collection is best to use in certain research situations.

They will learn sampling procedures (how to choose participants), how to create a survey or interview schedule and the relevant interviewing and data management techniques required to produce valid and reliable research. Another important aspect of research is the fair and ethical treatment of participants of the research, so students will develop knowledge of 'research ethics': how to manage information appropriately and confidentially and ensure that the risk of harm to participants in the research is minimised.

With reflection, it becomes apparent that, while learning the appropriate knowledge and skills to carry out both quantitative and qualitative social research, there is far more to researching than just knowing and applying the appropriate strategies or methods to a particular research project or problem. The principles of research are not solely for the purposes of the 'strategy' or the 'method'. Rather, they can also be construed as attitudes and values that are inherent to us as social care workers, due to the nature of our daily work. Research values and attitudes are based on a desire to garner information and to use such information for a purpose. Thus, it can be contended that the work of the social care practitioner and the values of research itself are inextricably intertwined. This is due to the often inquisitive or investigative nature of the work we do. In practice, there is the need to be ever-inquiring. There must also exist a perpetual pursuit of knowledge to enable us to work more effectively and for the betterment of the individual(s) we are caring for or supporting. This can be something that occurs not only in macro-level practice – in which we might, for example, be researching methods and models of best practice – but also at the 'micro' and 'relational' levels with those we work with. Thus, the importance of being able to participate in and lead research becomes obvious in the work we do.

Research Principles and Social Care Practice

In order to support a service user in their situation, during a particular stage of their life or within whatever social care context we are involved, social care workers must continuously engage with research. Inherent in the work is that we must find out about service users, their likes, their fears, their past, their hopes and dreams for the future, their medical, social and family histories, their dietary requirements, behavioural supports and so on. This process of finding out is arguably research in and of itself and crucial to the support of individuals in our care. This information provides the basis on which we, in partnership with service users, help them to make decisions about supports or about interventions required in certain situations.

The inquiry that we engage in as social care workers usually begins with us meeting the service user(s) for the first time. This, for the student on practice placement, can be a good time to consider how principles of research can be used to influence practice.

In this initial process of relationship-building, we may begin to ask questions of the service user about their life, their likes, dislikes and other questions that may help us to build a trusting, respectful relationship on which our support of the individual can be based and from which it can grow. It is important that, based on principles of consent, we seek permission to read any relevant files or care plans belonging to the service user. Information such as this can provide the data required to work more effectively, carefully and respectfully with the individual or group. This type of information-seeking is not fundamentally reliant on a specific process or framework of research.

'The basic foundation of practice research is building theory from practice.'

(Uggerhoj 2011)

It does, however, espouse the same attitudes, values, ethical principles and the desire to discover information that will inform the judgements and decisions that are made in the support of and in the collaboration with those that we support.

A practitioner or group of practitioners may carry out enquiry in order to better understand their own practice and client groups and to improve service effectiveness. These typically small and localised studies have the potential to be shared with colleagues working in similar environments.

The initial stage of developing a strong relationship with and a good understanding of the skills, desires and needs of the individual or group is crucial to the ongoing support of the service user. However, our inquiring, questioning or curious attitude does not end there. Social care work is such that we must constantly be aware of the changing needs of individuals and groups. In practice, this occurs through an ongoing awareness of the individual's progress, requests, behaviours and emotions. This information can be seen as the data that we gather from our observations and questions. Changes to any of these can be recorded in daily logs and filed as part of an information system. Furthermore, these changes may be discussed at team meetings, key working sessions, quarterly or annual reviews, safeguarding meetings, family or case conferences, and sometimes these discussions will be in consultation with multi-disciplinary professionals.

Practice-Based Research

TABLE
As a process, evidence-based practice involves:
1. Having a research question (i.e., a question that is driven by client need)
2. Engaging in a systematic review of existing evidence and search databases
3. Assessing evidence
4. Considering the results with a client
5. Drawing conclusions and intervening appropriately

It can be contended that practice based research is highly compatible with social care work as a means of producing an evidence base to inform practice. Practice research is considered a 'bottom up' approach to research and it occurs as part of our everyday work. Flyvberg (2001) suggests that no one person can provide the answers or true insights into a particular phenomenon, thus practice research emphasises the input of all stakeholders in the research process. One of the central tenets of practice research is the concept of 'evidence based practice'. Summerskill (2005) suggests that evidence-based practice requires that decisions about care are based on the best available current, valid and relevant evidence. These decisions should be made by those receiving care, informed by the tacit and explicit knowledge of those providing care, within the context of available resources. Practice research can take the form of action research, community-based research, small-scale research projects and case studies, for example. These forms of research rely heavily on the principles of involvement of all stakeholders, as outlined earlier, and the social care work is central to this facilitating this type of research.

Case Study 1

Practice research might take the form of a group of social care workers coming together within their organisation to conduct a study to better understand a particular issue/phenomenon in the organisation. For example, if there is a pattern of service users being dissatisfied with a particular educational programme in the service, practitioners may engage in a practice-based, small-scale study to identify the underlying causes of service users' dissatisfaction. This might involve a focus group or individual discussions with relevant stakeholders in order to ascertain the facts about the problem, the findings of which can be used to implement changes in the programme if necessary.

Clinical and Academic Research

It is unlikely that social care workers, by the nature of their professional role, will participate in or lead clinical research per se. However, some social care workers may decide to further their study in related disciplines such as psychology or psychiatric-based practices, taking their knowledge-hungry and inquisitive attitudes with them. Clinical psychology and psychiatry, for example, integrate scientific enquiry, knowledge and theory as a basis for understanding and are heavily dependent on research. They involve rigid research methods and research is carried out 'on' people with the focus of understanding more about health, disease or dysfunction, for example, and can strive towards finding or improving new treatments or increasing levels of a person's care.

Social care workers will have an understanding of the application of clinical research, as training often provides modules in clinical and abnormal psychology as part of professional qualification. These modules give learners an understanding of psychological and psychiatric disorders and the current means of diagnosing these disorders, which is important where service users in their care present with such issues. Students are made aware of the role of research in informing both theory and practice in abnormal and clinical psychology and the ethical considerations employed within related research practices. Social care workers will often find themselves working in multi-disciplinary teams alongside medical professionals, psychologists and psychiatrists. These disciplines, the knowledge and theory on which they base their practice, are heavily reliant on clinical research to inform their diagnosis, interventions and the care of individuals. Therefore, social care workers must have knowledge of the type of research on which such disciplines rely.

It is imperative that social care workers engage in academic research in their training and education. Social care workers can immerse themselves in this type of research throughout their practice careers. Academic research, as a way of learning about individuals, groups and societies, begins with a student's search for relevant literature, articles and research papers to inform them in their essay assignments and other college tasks. Writing a literature review of a particular social phenomenon, for example, involves following the steps that guide planning, organising, information gathering and writing. There will also be a guide in relation to referencing (e.g., the Harvard system) and/or creating a bibliography. Academic research is not confined to college learning. It is something that social care workers can involve themselves in throughout their careers, whether they work in practice or elsewhere.

Influencing Practice through Research

There are numerous ways in which social care workers can influence their own practice and the general practice of social care. For example, they could can disseminate a piece of work by submitting their research or academic paper to relevant social care journals in Ireland or internationally. They might also present their work at social care and/or related conferences such as the annual Social Care Ireland conference. They can influence the practice of their organisation by engaging in practice-based research and by encouraging others to engage with this philosophy. Whatever the topic of interest, the type of research or the methodology involved, the research process involves similar steps. It is important that those undertaking a degree in social care develop the necessary knowledge, skills and attitudes required to participate in, develop and lead research for their own continuous professional development, to inform and improve the work they are involved in.

Participating in or Leading Research

As outlined above, a positive attitude to research in practice and an understanding of its benefits is an important aspect of what it means to be a social care worker. Social care workers must also be willing to participate as 'research subjects' where others are carrying out research that may be used to inform practice for the betterment of all stakeholders. Some of the skills that need to be developed in order to carry out, participate in or lead research are those associated with communication, motivation, organisation and management, relationship-building, delegation and motivation. As a student, you will hone your academic, writing and project management skills throughout your education and these skills will be useful in carrying out research throughout your career.

Tips for Practice Educators

Practice educators should consider how they might enable the student to develop their academic and practice research skills and to meet this proficiency during the student's placement. Practice educators might provide the opportunity for the student to discuss how practice-based, clinical or academic research could be useful in informing either a piece of work with a service user or group and to discuss the implications of such research for the individual, group and organisation. This could occur during a supervision meeting. The practice educator may identify the need for a small-scale piece of research within the agency and thereafter support the student to design the study, to do some reading which might inform the research and guide the student in carrying out the data collection process. Following this, the practice educator may assist the student in writing up their findings and collaborate with the student in deciding how to implement these findings if necessary.

Such a piece of work can also provide the opportunity for the student to develop many other proficiencies. These include working autonomously and accountably throughout the research process, being able to manage the project/workload and adhering to the ethical principles involved in the research. It might also be an opportunity to develop communication, collaborative practice and relationship-building skills. The student should apply the knowledge acquired during their college course to the research task and develop new knowledge through any reading that might be necessary to inform the research.

It is important to include opportunities to reflect on the process of carrying out the piece of research, both during and after. This can provide the space for the student to identify and consolidate any learning that may have occurred during the process. It also gives the student the opportunity to consider what they did well and what skills/proficiencies they need to develop as their education progresses.

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Chapter 79 – Gillian Larkin

Domain 5 Standard of Proficiency 18

Know the basic principles of effective teaching and learning, mentoring and supervision

KEY TERMS

Teaching
Supporting
On-going learning
Continuous professional development

Social care is ... about working with people with various difficulties and issues in partnership to find the right support so they can live empowering independent lives.

According to McSweeney and Williams (2018), social care practice encompasses knowledge from disciplines such as psychology, sociology, human rights in addition to the use of evidence-based practice. As well as an extensive knowledge base, social care workers require an array of skills including communication, active listening, boundary management, assessments, interventions (Allen & Langford 2008), while values of human rights, anti-discrimination, anti-oppression, empowerment, social justice, and equality provide the context in which we work (Lalor & Share 2013). In practice, this could mean working with several service users at the one time, all with different needs, utilising a range of skills and knowledge specific to each person so that their care is person-centred to them. In addition, social care workers need to work in and understand the legislative and policy framework of the organisation in an often changing environment. In my experience, social care professionals work under conditions of complexity and uncertainty and require a combination of theory and skills to deliver safe, effective, and efficient person-centred care (Turpin, Lynch & Spearmon 2015; Lalor & Share 2013).

Developing and maintaining these skills, values and knowledge is challenging due to the evolving nature of social care development, the ever-expanding evidence base, and caring for service users with often-complex social and emotional needs. Consequently, social care staff, whether in the learning, graduate or experienced phase of their career, are all learners.

TASK 1

Think about...

We can all remember those times when we experienced being new to a situation: first day at school, first day on placement, and the first week of taking up a new post in a social care setting.

Take a moment to think back to how it actually felt to be a student on placement/a new member of staff.

- *What are some of the main issues you think your students/graduate staff members/new experienced staff might be facing being in a new work environment?*
- *What might you as a social care worker do to help them?*

The Multiple Roles of a Social Care Worker

A social care worker does not focus on just the service user, but on students who are undergoing their placement, on graduate social care workers, on peers and on the self. This means a social care worker could be supporting a student on placement, mentoring a colleague, acting as a supervisor to colleagues and engaging as a student as they continue in their professional development. Therefore, social care workers are teaching others and learning through their interactions with students and staff, through supervision, mentoring and personal development.

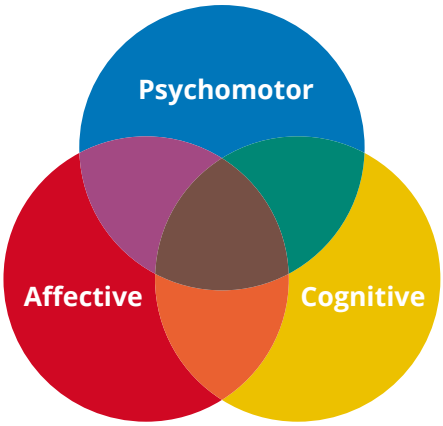
An On-Going Learning Journey

Social care students receive training to prepare them to work in such a diverse field, both in the classroom and out in the practice environment through student placements. Within the education setting syllabi, student handbooks, assessments, evaluations and tests provided to the student ascertain their understanding and development. This learning process provides various guidelines and clear expectations, and when a student struggles to meet expectations there are supportive steps and interventions. Students receive a continuation of their social care education in practice placement. It is here where students apply theoretical knowledge and proficiencies, develop their practice skills and professional values, understand the working of a social care organisation and become more aware of themselves and their learning needs, through supervised participation in the work of a social care agency (IASCE 2009).

Once qualified, social care workers engage in Continual Professional Development (CPD). The Health and Social Care Council define CPD as "the means by which health and social care professionals maintain and improve their knowledge, skills and competence, and develop professional qualities required throughout their professional life" (CORU 2013). CPD can include different activities*; Mary has recently trained as a Practice Educator while Lukas has attended a conference on Resilience in Children, and Francis is undergoing Key Worker training.*

Teaching and Learning

Teaching is an important part of the professional's role and members of the social care profession teach students and other staff at some point in their career. Teaching involves setting appropriate learning experiences and includes activities/opportunities or kinds of interactions that lead to learning new information, skills and ways of thinking and being (Taylor & Hamdy 2013).



Within social care, learning can occur in many ways. Jarvis (1983 cited in Hand 2006: 3) suggests learning can occur "...via the acquisition of knowledge, skills or attitude by study (course, training), experience (applying the theory/working with service users) or teaching (practice educator/supervisor/mentor)". Reece and Walker (2007) note there are three domains of learning: cognitive, affective and psychomotor (behaviour), and learning can occur from teaching, study or the assimilation of information and skills from experience.

The three domains of learning take place along a continuum and the more learning, practice and experience a student/worker has the higher levels of learning that occurs (see table below).

Cognitive Domain – think	Examples from Social Care Practice
Learning takes place across the six levels – knowledge, comprehension, application, analysis, synthesis, evaluation	A student has knowledge of Children's First Guidance (2017) prior to going on placement. In placement the student is asked to apply the legislation to a situation; a student may be asked to evaluate the effectiveness of the legislation.
Affective Domain – feelings/emotions	**Examples from Social Care Practice**
Concerned with attitudes, values, beliefs, opinions, interests and motivations Learning takes place across the six levels – receiving phenomena, responding to phenomena, valuing, organisation, internalising value	Learning activities aim to develop students'/ workers affective skills. For example – learning about discrimination helps students challenge existing views and opinions and incorporate new values within their existing value base. Students move from learning about a new concept to internalising it into their behaviour through practice, experience and further opportunities for learning.
Psychomotor/Behavioural Domain – doing	**Examples from Social Care Practice**
Psychomotor skills relate to the ability to convert the basic skills of knowledge and attitude into physical skills and hands-on applied and technical proficiencies related to movement, coordination and practices. Learning takes place across six levels – perception, set, guided response, mechanism, complex overt response, adaptation, origination.	Learning activities aim to develop students'/ workers behavioural skills through observing and copying to develop skills. For example, students become aware of the importance of body language as a form of communication and develop through imitation/ practice skills in identifying eye contact, body posture, gestures and facial expressions and learn until the skill is automatic, integrated into practice and adapted to different service users/ situations.

Source (Randall 2011)[1]

While learning is often associated predominately with cognitive learning, practice educators and mentors however must teach more than just knowledge and should guide students toward development within the affective and psychomotor domains, and in essence, the domains are often interrelated (Hoque 2017). Some examples may help in understanding how the learning occurs.

1 The following resources provide in-depth explanation of the three learning domains: Randall, V. R. (2011) Learning Domains or Blooms Taxonomy. Available from: https://academic.udayton.edu/health/syllabi/health/unit01/lesson01b.htm
Hoque, Md. (2017) 'Three Domains of Learning: Cognitive, Affective and Psychomotor', The Journal of EFL Education and Research, 2. 45-51.

Case Study 1

As an academic tutor I was on a placement visit and a student was telling me about her interaction with a service user who was attending a course in parenting support. The service user was not engaging with the student and her body language was closed off. The student remarked she found the service user challenging due to the lack of engagement and was quite impatient with her. In discussion the student demonstrated her understanding of the theory **(cognitive domain**) and her skills in reading body language **(psychomotor domain)** however the student had not demonstrated an unconditional regard (Rogers 1957) for the service user and was judgemental in the lack of engagement by the service user. The student did not demonstrate the correct attitude or professional manner **(affective domain)**, so this proficiency was not met.

Case Study 2

Student Princess was working with a young woman, Clare, who was seeking a job and had sought help to do up her CV. Clare had Spina bifida and experienced some paralysis in the lower part of her body so used a wheelchair. Princess was delighted to help her and typed up the CV. At supervision Jackie (practice educator) asked Princess to reflect on how the activity went. Princess felt it went very well as the task was completed. Jackie asked Princess if she could explain (**cognitive domain**) the ethos of the service. Princess was able to explain that the service was underpinned by an empowerment model. When asked to apply it to practice, she said it was empowering service users to do things and make choices for themselves (**cognitive domain**). Princess was asked did she empower Clare and she said yes. However, Jackie asked Princess to delve deeper into her practice and asked her "Did you asked Clare what help she needed?" "Did you let Clare take the lead in the task?" In discussion Princess learned that while her intentions were good, she had not valued Clare as an independent woman but rather her engagement with her was based on her belief (**affective domain**) people with disabilities cannot do or think for themselves. This supervision session enabled Jackie to teach Princess about her knowledge and beliefs via cognitive and affection domain learning.

Types of Learning

The European Commission (2001, cited in UNESCO 2009) has drawn attention to different kinds of learning, and have identified a typology of learning. This is of relevance to all social care students and professionals as it offers a lens through which we can determine what way we are learning. Rogers (2014) considers the notion of **formal learning**, which is intentional, structured, occurs in an education institution and leads to certification. This type of learning mirrors the educative and practice placement opportunities students engage in, and the CPD activities the professionals undertake.

Non-formal learning is also organised, intentional, certified and can include first aid training, SAMS training, report writing training and so on. A third type is **Informal learning** and results from daily life activities related to work, family or leisure. In most cases, it is non-intentional and frequently unconscious (UNESCO 2009: 27). Tannenbaum *et al.* (2013, 2010 cited in Cerasoli *et al*. 2017) believes once formal training has finished employees are provided with the potential for informal learning from their working environment. For example, I learned about Transactional Analysis (TA) and developed the skill of negotiation while working in practice.

Think about...

Have you learned a new theory, piece of legislation, model of practice while on placement or in work?

What new skills have you learned as a result of your placement or work?

Did you require support with your new learning?

Who offered you support?

Student-Centred Learning (SCL)

The notion of teaching and learning has moved from a teacher led style to a more student-centred approach. Harden and Crosby (2000: 335 cited O' Neill & McMahon 2005) describe teacher-centred learning strategies as the focus on the teacher transmitting knowledge, from the expert to the novice. In other words, the teacher is the driver of learning, and does not provide choice to the student in terms of what or how they want to learn. Conversely, a student-centred approach focuses on the principles outlined below and promotes a more collaborative process between the teacher and learner and one that is used within the social care environment:

Figure 1.2: Principles of Student-Centred Learning (O'Neill & McMahon 2005)

- The learner has full responsibility for her/his learning
- Involvement and participation are necessary for learning
- The relationship between learners is more equal promoting growth and development
- The teacher becomes a facilitator and resource person
- The learner sees him/herself differently because of the learning experience.
- The learner experiences confluence in his education (affective and cognitive domains flow together)

Exploring the Multiple Roles of a Social Care Worker

Practice Educator

The Practice Educator is a member of the social care team who works with a student to maximise learning on practice placement. This includes identifying learning objectives, monitoring their learning, engaging in supervision sessions and assessing student development in conjunction with the student's education provider. Through participation in this learning environment, students integrate theory based learning with the realities of practice and through which professional competence is achieved (Alsop & Ryan 1996). In effect, Davys and Beddoe (2000) note the role essentially involves managing, assessing, monitoring, teaching, challenging and supporting the student. What a hugely important role practice educators provide to the social care sector. As articulated by McSweeney (2016), practice educators are essential in the education of social care workers.

Stop!

Are you a Practice Educator?

If yes, give yourself a huge clap. You are an essential part of social care learning and development.

Do you work with a colleague who is a Practice Educator? Shout out well done, give them a clap, buy them a coffee and a scone – you choose!

Are you thinking of becoming a Practice Educator? Thank you!

We can all remember the time of being a student – the not knowing, of being unsure, of being afraid, of not being sure if we would make it!

To my practice educators, to the practice educators of today and tomorrow – keep up the good work!

Bastable (2014) argues it is essential for a practice educator to have knowledge (of the material to be learned, the learner, the social context), and be competent (be imaginative, flexible, and able to employ teaching methods, display solid communication skills; and have the ability to motivate others) to facilitate effective learning with students. Thus, it is necessary for social care workers who take on the role of a practice educator to engage in on-going professional development.

Learners as a Resource

A key learning opportunity is when students are on placement. Students bring new ideas and knowledge, can challenge practices for both the practice educator and other staff and prompt increases in the practice educator's reflection (Mc Sweeney 2016). McAllister and Lincoln (2005: 1) found that practice education and the experience of having students offered "opportunities to both educators and students for professional growth" and that this professional growth and development implied a "movement along a continuum of professional skills and competencies".

Examples from Student Placements

Student Fiona noted that first thing in the morning on placement, a staff member was tasked with waking up each service user at 8am regardless of whether they were going to school or Youthreach, which led to difficulties when the young people would not get up. Fiona asked if those not getting up for education could be left until those going to education had gone? In the team meeting, the staff remarked they had been doing the routine for so long, it was no longer fit for purpose, but no one thought to change it.

In a supervision session, a student explained the Social Role Valourisation Theory (Wolfensberger 1983) to the practice educator, who was engaging in such practice, but did not know the evidence base behind it.

Another student provided a presentation on New Directions as the staff team were unfamiliar with the guidelines.

Supervision and Mentoring

To ensure a supportive teaching and learning environment, the 'teacher' needs to demonstrate a genuine non-threatening relationship with the 'student'.

Bernard and Goodyear (2013: 7) define **supervision** as "an intervention provided by a more senior member of a profession to a more junior member or members of that same profession", or in the case of a student placement, is provided by the practice educator to the student. Morrison (2003) proposes that the purpose of supervision is to enhance the social care worker's/students professional skills, knowledge, and attitudes in order to achieve competency in providing quality care. Supervision is documented and thus is an evaluative process (Saliba 2013). The follow example demonstrates how supervision prevented a student from leaving her placement.

> *"It was my first week in placement and I was struggling. I had never worked with people with disabilities before and found I could not understand when they spoke to me, and one service user threw her bag at me because I kept saying 'pardon, sorry, pardon'. At my first supervision I told my practice educator I was leaving as the service users did not like me and I cannot understand what they are saying. I was crying as I always wanted to be a social care worker but was rubbish! My practice educator was amazing. She let me say how I was feeling* ***(affective domain)*** *and then asked me to tell her all the interactions I had with service users that were positive. I struggled but named two. She explained to me that all students experience difficulty with service users initially and communication is a skill* ***(psychomotor domain)*** *I will develop during placement through practice. We discussed theory that would help me* ***(cognitive domain)****, and we explored other reasons why the service user may have been cross* ***(cognitive domain),*** *and I identified 2 skills* ***(psychomotor domain)*** *that I wanted to achieve around communication before my next supervision session. We then discussed my feelings in regard to the service user being cross with me and how I attributed my inability in understanding the communication to being 'stupid' and my subsequent reaction. Through the discussion I learned that I had no awareness that I was valuing myself against my engagements with the service users, and when I perceived that things had not gone well, it was an indication of my lack of ability, which led to an overload of emotion. To try to increase my awareness around my feelings* ***(affective domain)*** *and what were triggers to feeling good, bad, confident etc. my practice educator asked me to journal my feelings on a daily basis with a view to helping me making connections between feelings and behaviour (Year 2 Social Care Student)*[2].

Similar to supervision, **Mentoring** also involves two parties (a mentor and a mentee), a relationship (formal or informal), and the transfer of skills, knowledge and attitude with the objective of development growth of the mentee (Bilesamni 2011). Megginson and Clutterbuck (1995: 13) define Mentoring as "offline help by one person or another in making significant transitions in knowledge, work or thinking". Unlike supervision, informal mentoring is not an evaluative process (Inzer & Crawford 2005).

Within social care mentors can be a peer or a senior member of staff who offer informal support to new graduates as they can experience a variety of developing challenges that may impact on competent practice, may feel inadequately prepared to practice independently, or navigate the complex responsibilities required. Taherian and Shekarchian (2008) note engaging with a mentor can help increase a mentee's motivation and empower and encourage them which can raise the performance bar, while as a result of nurturing self-confidence, teaching by example and offering wise counsel mentors can experience higher levels of well-being and work satisfaction (Morgan & Rochford 2017).

2 Reproduced with permission from student reflective assignment

The following examples demonstrates the difference between mentorship and supervision, and the role of evaluation.

Supervision Example

Martha is a supervisor for Anthony, a social care worker who has been on the team for three years. This is a very structured relationship. There are regular meetings that support Anthony around the three supervisory functions of education, support and accountability (Kardushian, 1992). During the most recent supervision session, Anthony talked about finding it difficult to work with one young person in the unit, as this young person's behaviour had escalated and there is limited interaction with the staff team. As his key worker, Anthony felt he was not able to help the young person. He was feeling very low and a little angry as he had worked hard with the young person and felt the lack of engagement was a reflection on him, and really felt the young person ungrateful.

During this session, Martha asked Anthony to evaluate the young person's behaviour from a theoretical basis ***(educative function)*** *and reflect on why he was taking the young persons' actions personally. Martha acknowledged the anger he is feeling and while supporting Anthony with his feelings (****supportive function),*** *highlighted this anger could seep out into his practice with the young person, which would be a boundary violation (Davidson 2005) (****accountability function****). Through discussion, Anthony said he was not sleeping well due to a new baby at home, and this was affecting his work. Martha spoke to Anthony around different options of self-care and invited Anthony to a further supervision meeting if needed. In line with regulations, Martha documents the supervision meeting.*

Mentoring Example

Josephine has been mentoring new staff in the team for the last five years. She has fifteen years of social care experience and has worked in a variety of services before taking up her role in this service nine years ago. Josephine works informally with the new staff for a period of six months depending on the needs of the staff member. During this time, Josephine supports the new staff member to settle into the staff team, build relationships with all the stakeholders, offers feedback and provides new learning strategies, based on her knowledge and experience, to help the staff member become competent and confident in their practice. Josephine really enjoys this role as it allows the new staff to be open about their practice and seek support without being concerned of evaluation, as can be the case in a supervision meeting.

Tips for all Learners – What Helps Learning?

Roger's (1957) discusses three core principles to facilitate a therapeutic change, that of congruence, empathy and unconditional positive regard. As learning is also about change, the right environment is essential to ensuring optimal development. Hand (2006) has outlined some characteristics as essential to supporting learning which fit nicely in our roles of teacher and learner:

- Listening and responding consistently
- Helping the 'student' to identify feelings and personal knowledge
- Sharing of self with the student
- Being sensitive to the students' needs
- Valuing the learner as a person respecting and caring for his/her feelings and opinions
- Showing empathetic understanding
- Being aware of personal strengths and weaknesses and their effect on others

TASK 2

Activity:

Identify an element of your practice that you need support with and look around your staff team and select someone who you think may be able to help you. Explain your issue and seek their help.

- *How does it feel being the learner?*
- *Ask your colleague how it feels teaching you something new?*

Case Study 3

Philip has recently graduated and is three months into his job as a social care worker and is finding things difficult. He loves the work and is really enjoying working with the young people but is not sure if he is doing the work 'right'! All of the other staff seem so sure of themselves and know how to deal with all situations with the young people. Philip thinks he has made the wrong career choice. Philip has spoken to his mum and she has suggested he talks to his supervisor however, Philip was adamant he would say nothing as it would look like he was rubbish at his job, and he is on probation.

- *What are the benefits of providing Philip with a mentor?*
- *What will be the mentor's role?*

Case Study 4

Sonia has been working in Cedar Family Support Services for three years and is struggling in her role. She has been working with the Byrne family for three months and is finding it difficult to separate her feelings to the mother Denise from her own personal experiences. On a number of occasions, she was quite judgemental towards Denise, and could not accept how she could forget to feed her children, and send them to school with no coat, to the point that five-year-old Sadie was hospitalised with a severe chest infection. Sonia could not contain her displeasure at those poor children experiencing neglect so asked a colleague to work with Denise last week; Sonia knows this is not a long-term option. Sonia's supervisor has noticed she is not engaging with her service user as she normally would and has asked to have a supervision session with her.

- *What do you see as the issues Sonia is experiencing?*
- *In your opinion, does Sonia need a supervision or mentoring session? Please explain your choice.*

Case Study 5

Sunita is preparing the schedule for her new social care student. Sunita has been a social care worker for six years and has extensive experience in supervising students. This is her fourth year as a Practice Educator. Sunita likes to engage in weekly supervision sessions with the student as this allows her to keep a check on student development, complete the college supervision logs and assess how the student is progressing in meeting the relevant proficiencies.

In preparing the schedule, Sunita provides opportunities that allows the student to develop in all areas including knowledge, legislation, models of care and application to practice. Both Sunita and the staff-team demonstrate ethical practice, skills in how to engage, communicate and work with service users, and develop reflection skills. Students are taught to be responsible and accountable for their decisions and actions through the allocation of roles and duties.

Supervision allows students to reflect on their practice and discuss areas that are going well for them and challenges that need support. In this space, students are given the time to talk about their emotions and feelings, their judgements and biases. In her role, Sunita offers the student constructive feedback on what has been observed by herself and colleagues in practice and this creates awareness and opportunities to enhance practice, feelings, emotions and skill development.

A key part of the practice educator role is to support the student to think critically and Sunita does this through asking questions and supporting the students to draw on many theories and skills to search for the most appropriate approach. Sunita also provides access to training such as report writing, Manual Handling, First Aid, SAMS and MAPPA.

- *In your opinion, what other opportunities are there for Sunita to teach her student?*
- *Can you think of any opportunities where the student may be able to teach Sunita?*

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Chapter 80 – Christina Sieber

Domain 5 Standard of Proficiency 19

Demonstrate an understanding of the importance of one's own personal growth and development in order to engage in effective professional practice whilst developing the personal skills of self-care and self-awareness in the role

KEY TERMS

Personal growth and development
Self-awareness
Self-care
Reflective practice
Reflective writing/ journalling

Social care is … about relationship developing, building, nurturing, self-care, awareness and reflection. It is impossible to care for others if you do not care for yourself.

TASK 1

Reflecting on Practice

As a social care worker (or a student in training), think of a time you supported another person to make a decision that involved an element of risk. How did you weigh up the benefits versus the risk? How did you support that person?

The Importance of Personal Growth and Development

An understanding and engagement in personal growth and development is an essential tool in the training of social care workers and in the practice of social care work. The use of self-care, self-awareness and reflection can help a social care worker engage in effective professional practice and explore aspects of themselves that may make them vulnerable. Using these tools in supervision can help to guide a supervisor and supervisee through difficult events and situations.

What is Self-awareness?

Awareness is about what you notice in life and in the world. It involves paying attention to what is happening around you. Forms of awareness are different for everyone and there is no right or wrong way of being aware. It is about how you experience life. So, if awareness is about noticing what is going on in the world, self-awareness is about focusing what you notice and your awareness of yourself. While there is no correct or incorrect way to be self-aware it is important to be able to focus on your feelings, your reactions, your behaviours and your thoughts. One way of becoming self-aware is to practise self-care.

What is Self-care?

Self-care is something you give yourself. It is any task that helps our mental, physical, and emotional health. Taking care of our wellbeing through self-awareness and self-care is a vital component in engaging in personal growth and development as a social care student or social care worker. There are many tools that can aid in this task. One way of becoming self-aware is to have a self-care plan. Constructing a self-care plan when times are good can help to focus you when life and/or work gets hard and you need a reminder of how to get back on track.

TASK 2

How do you self-care? What self-care techniques work for you?

Write down a couple of ways in which you engage in self-care in your life. Use these to create a self-care plan to look after yourself.

Another way of engaging in self-care and effective professional practice is to become reflective and to keep a reflective journal. This should be encouraged throughout social care training and when in practice.

Reflective Practice

Reflection can be defined as how a person perceives an experience, thinks and reflects on that experience and then uses their reflection to learn from that experience (Kolb 1984). **It is the learning gained that is important**. 'Wellbeing' is a term used frequently when discussing people's mental health; similarly, the term 'reflection' is important when talking about well-being in personal and professional life.

Dewey, quoted in Carlile and Jordan (2007: 27) suggested that reflection can be defined as 'turning a subject over in the mind and giving it serious and consecutive consideration'. Kolb (1984: 38) spoke of learning being 'the process whereby knowledge is created through the transformation of experience'. Gibbs (1988) added that it is not enough to have an experience; the important part is the process of thinking about it, and this new learning shapes how we react to similar situations.

Moon (2004: 82) defined reflection as:

> A form of mental processing – like a form of thinking – that we may use to fulfil a purpose or to achieve some anticipated outcome or we may simply 'be reflective' and then the outcome can be unexpected. Reflection is applied to relatively complicated, ill-structured ideas for which there is not an obvious solution and is largely based on the further processing of knowledge and understanding that we already possess.

Reflective Writing/Journalling

The act of reflective writing/journalling can provide individuals with the opportunity to make meaning of their past experiences. They can then relate those experiences to present circumstances or their current opinions and evaluate how they might influence the way they approach new circumstances. The act of reflective writing/journalling can help individuals consider experiences and connect them in a way they may not have done before.

Reflection and reflective learning have also been compared to a toolbox (Lyons 2010). Like a physical toolbox, the reflective toolbox is a go-to place where individuals can draw on past experiences and reflections which can help in current situations. Reflection is a skill that can be learned and it can aid in personal development. Reflecting on a situation and analysing it can help one learn from experiences and can also help one be prepared to deal with situations in the future. At a personal level, perspective on situations and better decision-making can also be gained.

Case Study 1

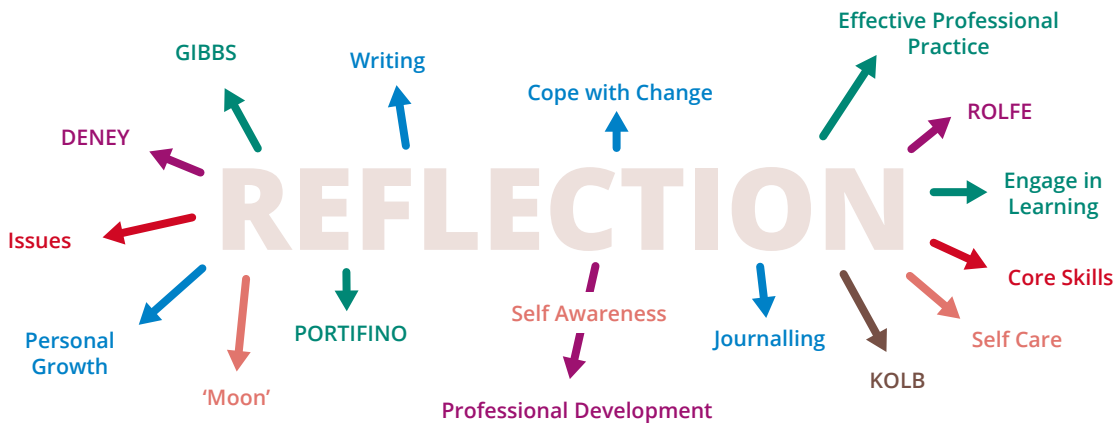
You are a new member of staff in a social care setting. An incident occurred during your first shift and the way it was dealt with by an experienced social care worker is playing on your mind. While the incident was resolved positively you have many questions as to the practice of the social care worker in question.

Your monthly supervision meeting with your supervisor is in a few days and you are unsure whether or not to raise the issue.

TASK 3

Reflect on this case study.

Thinking about the case highlighted above, how might reflective practice before and during supervision support you if you encountered a similar case in the future?



Engaging in Effective Professional Practice: Reflection and Professional Growth and Development

At a professional level, the skill of reflection is a vital aspect in evaluating situations (at times dangerous) and making decisions about these situations. This skill is essential in the social care sector, where registration and competence practice will be a requirement. One of the prerequisites of registration is the completion of and submission of a portfolio of continuous professional development (CPD) to the registration board (CORU) and four reflective pieces about practice must be submitted as part of this portfolio. The skill of reflection is essential in putting an individual's knowledge to good use (McCann *et al.* 2009) and in taking responsibility for one's actions and values where one lives and works (Bolton 2010). The aim of this is to evaluate the effect of their own characteristics, values and practices on interactions with service users and to be able to critically reflect on this to improve practice (SCWRB 2017: 5).

Conclusion

An understanding of personal growth and development is an essential tool in the training of social care workers and in the practice of social care work. Self-awareness and self-care are critical components in developing as an effective professional. Reflection is vital in ensuring that the practice of social care work is one that is fulfilling to the worker but also beneficial to the people we care for. It is through this awareness and reflection of the self that we can truly care for and engage with the most vulnerable members of our society – our service users.

Tips for Practice Educators

- Encourage your students to keep a free-flowing narrative journal (this can help to guide supervision).
- Encourage them to write in this journal at least once a week.
- The purpose of keeping a journal is to support the student in developing the skills necessary to become a professional social care worker.
- The process of writing forces us to deal with our ideas in a concrete form, and undoubtedly leads us to a deeper examination of what we are thinking.
- It helps us to clarify our thoughts and identify gaps in our understanding.
- Written accounts allow us to see our progress as our learning expands.
- A written record is also useful in our continued reflection and revision of what we have learned and experienced.

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