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The Irish Social Worker

Relationship based practice central to Social Work

Summer 2017

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EDITORIAL

Dear Members,

I am pleased to be able to present this summer edition of "The Irish Social Worker" journal. The title is "Relationship based practice central to social work." While it could be argued that every social work journal could have such a title, I do think in this particular journal a number of articles focus specifically on this theme. Following the IASW National Social Work Conference which had the theme "Of Hearts and Minds: The Practice of Social Work Relationships," most of us present have, I think been motivated by our key speakers on the day, to value again what is special about our profession, namely the emphasis we give to forming and maintaining relationships with those we work with.

I would like to thank the members of the Journal Committee Steven Peet, and Majella Hickey who have assisted me in reviewing every article submitted and in offering constructive feedback. While conscious of the costs of publication we aim to produce two quality journals a year.

On behalf of the Journal Committee I would like to express our gratitude to all the authors for contributing to this generic social work edition. In particular I would like to thank Erna O'Connor who managed to turn her presentation at the National Social Work Conference into a stimulating article within a very short time frame.

The Journal Committee appreciate that we all live busy lives and particularly for social work practitioners finding time to research and write an article is no easy task. But it is usually worth the effort in the end as you develop a more detailed understanding of your topic of interest and you leave a legacy of knowledge for your colleagues for the years ahead.

The Journal Committee would like to encourage all of our members to submit an article for publication. The Journal Committee welcomes both research based articles and also articles with a reflective practice focus. The Journal Committee will offer support and guidance as required. All articles published in the Irish Social Worker Journal will be available after six months, (with the author's permission) to Lenus the HSE open access repository for Irish health publications. This facilitates authors to disseminate their work to a much wider audience both in Ireland and internationally.

I hope you will enjoy this summer journal edition of the Irish Social Worker.
Frank Browne A/Editor

THE COMPASS OF SHAME: a refelective tool in developing self-awareness and enhancing and maintaining effective relationships.

(This article was first published in the Irish Foster Care Association's journal, 'Foster', Issue 3 (2017).)

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Abstract

Shame is an under-explored emotion that is beginning to receive more attention within the social work profession. Unhealthy shame can be a major inhibitor to the establishment of safe and trusting relationships. Both the caregiver and the child can be prone to unhealthy shame thereby underlining the fundamental importance of understanding its negative consequences.

This article is located within a criminal justice context and is based on my experience of working with adults and children vulnerable to shame. It outlines the theoretical aspects of shame and explores the role shame plays in emotional maturation and the attachment, rupture and repair cycle between the caregiver and the child. It explores how my knowledge and understanding of the compass of shame (Nathanson 1992) helped me to unravel intense and powerful emotions, unblock negative feelings and enhance self-awareness and learning. The article concludes with a discussion on the risks and challenges and key themes for social work practitioners and caregivers to consider when working with clients and children who are vulnerable to shame.

Keywords: Shame, Caregiver, Attachment, Reflective tool.

Introduction

As a social work practitioner, my interest in shame developed through my engagement with personal therapy and interaction with a supervisor with extensive knowledge of and experience in the area of shame.

As an experienced practitioner, I frequently felt perplexed at my attempts to build relationships with young children and adolescents with challenging behaviours. In response to my concerns and observations, a supervisor introduced me to the concept of shame. This knowledge and understanding has enhanced my relationships with people and enriched my professional career as a social work practitioner

What is Shame?

Shame is a complex phenomenon which can be very difficult to describe and understand. According to Harper (2011) the word shame has its origins in the pre tuetonic root "skem" and the French tuetonic root "skam" which means "covering" or "covering oneself". Loader (1998, p.44) describes shame as a "powerful emotion associated with the exposure of any aspect of the self that we wish to keep hidden". Kaufmann (1999, p.18) describes the affect of shame as sudden, unexpected, exposure and inner scrutiny which has the capacity to bind speech, interrupt movement and violate internal security and interpersonal trust.

Healthy Shame

Shame has both negative and positive functions. Lewis (1971) states that shame plays an important role in the regulation of all emotion and in particular during emotional maturation and the attachment rupture and repair cycle between a child and its caregiver. When a child feels anger frustration or sadness, the "good enough" caregiver attempts to understand their infant or child's internal mental states.

During the child's struggle for independence (from aged two), frequent periods of rupture may occur in the caregiver - child relationship, as the child attempts to separate and the caregiver attempts to socialise and protect and limit the child from danger. Schore (1994 cited in Walker 2011) describes how healthy experiences of shame develop during a young child's socialisation. When a caregiver limits the child by saying no, it causes a healthy experience of shame whereas, in contrast, the distressed child will hang their head, avert their gaze and lose their smile. If this lack of attunement between the caregiver and child is short and tolerable the child learns to deal with stress. Through the support and understanding of the caregiver, the child learns to acquire language to describe their feelings. Subsequent rupture feels less catastrophic, repair happens faster, and trust, compassion and connection deepen.

Unhealthy Shame

When a lack of attunement between the caregiver and child is frequent, chronic and long-lasting, it allows unhealthy shame to develop. Walker (2011) describes how this can happen when a caregiver is unable to understand the child's mental states for reasons such as mental illness or addiction. A woman I counselled in the past described the sense of shame she felt when her son presented her with drawings he had completed at school. In each and every drawing he had depicted her holding a glass of wine in her hand. Struggling with alcoholism, she recalled how she reacted towards her son with rage, threatening him not to draw any more pictures of her. Another client described a visit to her dying mother when she was a young child. She described how difficult it was to see her mother so upset and distressed. Unable to cope, she turned to her father for emotional support. She described how, threatened by the presence of emotion, he responded to her feelings of helplessness and fragility with insulting comments and criticism. She in turn responded by internalising a sense of herself as being weak. From an attachment perspective, as children are completely dependent on their parents for survival, internalising such emotion allows them to maintain a positive image of their parents as caring adults (Walker, 2011).

Kaufmann (2009) describes a number of patterns where unhealthy shame can develop in a dysfunctional caregiver-child relationship. He describes how resentment towards a child is generated when either or both parents do not want the child or had desired a child of the opposite sex. In this case, a second pattern develops where a parent might say "I wish you had never been born". A child may be expected to meet unrealistic expectations, live out unfulfilled dreams or make up for the deficiencies of the parent. In such cases, the child is not seen as a separate individual but as an extension of the parent. A third pattern of unhealthy shame develops when a parent is not present to meet the child's needs and the relationship is reversed, with the parent looking to the child for parenting. This may be because the caregiver has a poor history of stating their own needs and asking for support and help. Asking for support so that they can meet their children's needs might be anxiety-provoking and trigger feelings of vulnerability, fear of judgement, and shame.

Recognising Shame

The facial signs of shame are particularly notable in young children (Kaufmann, 2009). These include hanging the head, biting the lip, a false smile, blushing and lowering or averting the eyes. There are also a number of secondary reactions to shame that can easily be misinterpreted and ignored such as rage, denial, perfectionism, lying, blaming and withdrawal:

- Rage – can be used as a defence to protect and insulate the self against further sudden exposure. Consider Walker's (2011) example of assessing men who have anger management problems. He states that when he looks at triggers of their anger with them, it can frequently be traced to a feeling of humiliation or uselessness.
- Denial – shame feels so overwhelming that the person is unaware that they have a problem. Consider Potter-Efron's (1989) example of an alcoholic who denies their drink problem. Their fear of shame is so tremendous that they convince themselves that they could not be an alcoholic and are blocked to the evidence of their addiction.
- Perfectionism – can be used as a defence to protect and uphold a person's self-image of being perfect. Adults and children who are prone to perfectionism may have grown up in homes where roles were rigid and inflexible and where they were expected to adhere to super human rules and unrealistic expectations. Consider Potter-Efron's (ibid) example of the messages a 13-year-old boy receives from his parents having achieved Four 'A's and one 'B' in his school exams. His parents convey the message that when they were at school they never settled for less than straight 'A's, and he will have to do a little better the next time.
- Lying – can be used as a protective mechanism to cover up imperfections and mistakes and to avoid and repress the shame of frequent failure.
- Withdrawal - can be used as a survival strategy in situations where people feel vulnerable and exposed, and wish to escape from the humiliation of feeling judged. It would be common to hear people say things such as, "I just wanted a hole to open up and swallow me".
- Blaming – can be used as a protective mechanism for people who find it difficult to take responsibility, apologise or make amends.

The Compass of Shame: a reflective tool in developing self-awareness

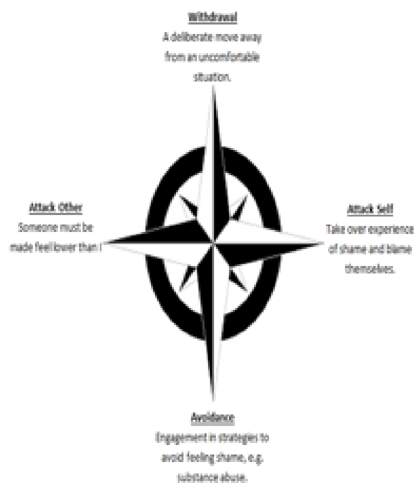

Fig 1. The Compass of Shame
Adapted from Nathanson Compass of Shame (1992).

The compass of shame (see figure1) is a tool developed by Nathanson (1992) to describe the four ways in which people defend against the feeling of shame:

- Those at the ‘attack self’ point of the compass take over the experience of shame by engaging in self - deprecating behaviour, for example, by listening to an internal voice that continues to put them down by saying, “I am pathetic” or “I am no good”.
- Those at the ‘attack other’ point of the compass attempt to disassociate themselves from the shame by blaming others, making other people feel small, engaging in derogatory commentary about other people or destructive behaviours, such as acts of vandalism or public order offences.
- Those at the ‘withdrawal’ point of the compass retreat into themselves to hide away from feelings of shame by removing themselves from the eyes of others. This helps them to avoid feelings of judgement or scrutiny.
- Those at the ‘avoidance’ point of the compass engage in activities to avoid and draw attention away from the shame, for example, misusing substances, denying their misuse, and denying that the feelings exist

The Compass of Shame; a reflective tool in developing self awareness

As an experienced social worker, I was supervising Harry, a 16 year-old child who had been placed on probation supervision by the Courts. When I met Harry, he had been placed in a high-secure unit. He described traumatic life experiences and a significant history of failed attachments and poor relationships with family.

Initially I struggled to build rapport with Harry. He presented as someone who was uncooperative, aggressive and angry. My inability to form a secure relationship with him triggered internalised feelings of inadequacy and failure. I wanted to feel accepted. I wanted to help him. I found it difficult to seek support and supervision in terms of guiding and directing my interventions with Harry. I felt I could not talk about the impact Harry’s behaviours was having on me. I felt I had to be seen to be coping.

As a self-protective mechanism, I learned to shy away from discussions with Harry about his concerning behaviour. In doing so, I was limiting the potential for conflict. While this provided temporary relief, I felt I was enabling the concerning behaviour and limiting his potential for change.

Through the support of an external supervisor, I was introduced to the concept of shame and the work of Silvan Tomkins (1962), the psychology of shame devised by Kaufmann (1989) and the wheel of shame devised by Nathanson (1992). My supervisor was able to recognise the facial signs of shame. When I was describing my difficulties with Harry, I was smiling, blushing and averting my gaze. He helped me to see that I was feeling exposed. He said, “Yes. When you smile, I can openly see your shame”. I immediately felt relieved and validated. He constructed a compass and asked me to describe the internal dialogue and defence mechanisms I was experiencing at each point of the compass when I felt exposed. His non-judgemental and open approach allowed me to express how I felt. Carroll (2009) refers to the importance of a relationship in which a person can trust they won’t be shamed and where they can take the risk of expressing their vulnerability without feeling judged. By using the compass of shame, my supervisor helped me to become aware of the following defences:

- At the ‘attack self’ point, I was taking over the experience of shame by listening to an internal voice that said “I am a fake”. “I am weak”, “I am not able to cope with this”. Deep inside, I did not feel good enough.
- At the ‘attack other’ point, I was taking over the experience of shame by attacking other. Someone or something must feel lower than I. I would say things like, “If Harry wasn’t so angry, I would be able to help him”, and, “If the government had a better care system, I wouldn’t be in this situation”. I blamed the university system who I felt failed to prepare me for dealing with such complex cases. The experience of shame lessened by shifting the blame towards Harry, the government and the university but I was learning little in terms of how I could facilitate change within myself.

- At the ‘withdrawal’ point I was attempting to distance myself from working with Harry. On one occasion, I suggested that Harry be reassigned to a male social worker. This backfired when Harry became extremely aggressive and angry towards me because he was being reallocated to another social worker. When this happened, I felt guilty, confused and accepted by Harry. He did not want me to leave.
- At the ‘avoidance’ point of the compass, I was drawing attention away from the problem by avoiding discussions with Harry and my line manager that would trigger feelings of inadequacy.

My supervisor helped me to take a step back and explore what may have been happening from Harry’s perspective. We looked at his background of parental abandonment and interpersonal trauma. As a self-protective mechanism, Harry may have been sabotaging the opportunity to create a deeper attachment with me for fear of further pain. We looked at interventions I could use to help Harry to restore his trust and faith in relationships:

Use of language

My supervisor suggested I start using language that is shame reducing. I stopped using language that might create defensiveness in the receiver such as using “Why”, at the beginning of sentences. For example, “Why are you getting so angry?” became, “I can see that you are angry. Tell me what is happening when we talk about this”. By doing this I was validating his anger and helping him to recognise that it was the subject and not I that was triggering his response.

I avoided the use of “you” at the beginning of sentences. For example, “You are making me feel uncomfortable when you are shouting at me” became, “I feel uncomfortable when you are shouting at me”. By doing this I was expressing my feelings of discomfort without attacking Harry and sending the message that it was his behaviour and not him personally that was making me uncomfortable. While the subject was difficult for him to speak about, he responded by becoming less defensive.

Normalising Behaviour

I started validating Harry’s experiences of interpersonal trauma and rejection. I normalised his anger response by saying, “Harry, that was really difficult and it is normal to feel really angry when you lose a parent and have been through all the experiences that you have encountered”. I helped him to see that anger is a normal part of the grieving process. By acknowledging the need to express all of his feelings, we were then able to focus on healthier ways he could use to express his anger. I suggested hitting a pillow on his bed when he felt triggered.

Naming the Shame

Over time, I introduced Harry to the concept of shame. Loader (1998) states that naming the shame helps release the bind it has over people. I asked him if he felt he could share the inner experiences and feelings which he felt he had to hide from others. Potter-Efron (2002) states that shame can only begin to heal when it is expressed in a safe environment. Empathetic understanding and unconditional acceptance can facilitate this safe space.

Compass of Shame

Using the compass of shame helped Harry to understand his defences and reactions. It helped him me to see that he was responding to his shame by using the following defences:

- At the ‘attack self’ point, Harry was able to see that he was taking over the experience of shame by listening to an internal voice. He would say, “If I hadn’t been so difficult, my foster mother wouldn’t have got sick”. “I caused her illness”.
- At the ‘attack other’ point, Harry was able to see that he was taking over the experience by blaming others. He would say, “adults are dangerous,” and, “they just can’t be trusted”. I heard him say “It was the social worker’s fault. She caused my anger”.
- At the ‘avoidance point’, Harry was able to see that he avoided dealing with his feelings by smoking cannabis.
- At the ‘withdrawal’ point, Harry was able to see that he withdrew his love from other adults and children to protect himself against further hurt. He felt that by becoming angry with them he would keep them at a distance by frightening them away.

Through the restoration of a safe and trusting relationship, Harry learned to label and express his feelings and emotions in a healthy way. And how were my skills enhanced? Identifying and naming the shame helped to overcome challenges within my practice as a social worker and enhanced my relationship with Harry. Through the support of my supervisor and the acquisition of theory and knowledge, I learned to identify, acknowledge, validate, respond to, and facilitate the expression of shame within myself and others.

Discussion

There are risks and challenges to consider when working with people who are vulnerable to shame. In my experience, the concept of shame was a difficult area

to grapple with and I had to work hard at finding ways to understand it and make it conscious in my work with others. I had to work at openly communicating difficult feelings, accept my own failings and limitations, and apologise and share responsibility with the client when I was doing something wrong. Having a supervisor with extensive knowledge and experience contributed to my understanding of the concept.

Gibson (2013) highlights the need for social workers to have a good theoretical knowledge of shame and to be able to recognise the visual and verbal cues of shame. Gibson states, "Understanding how behaviour is organized to cope with the experience of shame is crucial if practitioners are to respond sensitively and appropriately to both parents and children. Without this baseline, the style of practice may promote shame in the service user, which can result in behaviours which lead to a lack of progress and potential further abuse". Without knowledge and understanding of shame, Harry's behaviour might have resulted in a lifetime of searching for what felt painfully absent through illegal drug-taking and offending behaviour. Walker (2011) states that traumatised people often present with what looks like oppositional, resilient and difficult behaviours but it may be that their shame has impaired their capacity to communicate in an open and honest way.

Conclusion

Shame is a largely hidden and potentially destructive emotion. Unhealthy shame is a major inhibitor of the establishment of a safe and trusting relationship between caregiver and child. Developing awareness of how shame affects us is critical for enhancing and maintaining effective relationships.

Acknowledgement

I would like to acknowledge the support of Peter O' Sullivan, Psychotherapist for passing on his extensive knowledge and experience to me. I would also like to thank Dr. Carmel Halton and Dr Kenneth Burns from University College Cork, and Gerry Mc Nally, Elaine Geiran and Eloise Gillespie from the Probation Service for their helpful comments, guidance and support.

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Potential Benefits of Mindfulness for Young People who have engaged in sexually abusive or sexually harmful behavior and their social workers

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Abstract

Limited academic attention has focused on working with young people who have engaged in sexually abusive or harmful behaviour in Ireland. With this in mind, this article draws on a thesis and examines the views of professionals on the research question: 'Is there potential for the practice of mindfulness to be helpful for young people who have engaged in sexually abusive or harmful behaviour?'. This was researched through the use of semi-structured interviews and a field diary. The findings of this study were that there is a unique potential for mindfulness to be helpful for young people who have engaged in sexually abusive or harmful behaviour and were supported by the current literature. The thesis discussed the ability of mindfulness to: relax, aid the young people in transitioning from one situation to another, and give them a potential skill to aid in navigating and regulating their thoughts and emotions more effectively. Interestingly, the professionals interviewed reported similar benefits alluding to the potential benefits of mindfulness in social work too. These benefits do not seem to be currently available in any other method of working with young people who have engaged in sexually abusive behaviour in Ireland or abroad. Therefore, mindfulness holds a unique potential for aiding young people who have engaged in sexually abusive or sexually harmful behaviour and the interventions, particularly the Irish strength-based model discussed in this thesis. mindfulness, Buddhism, nonduality, young people who have engaged in sexually abusive or harmful behaviour, social workers.

Keywords: Mindfulness, sexual abuse, young people, social work

Introduction

Mindfulness has become an increasingly popular practice in the Western cultures. Mindfulness has been described as a way of paying attention and was most explicitly and systematically articulated and developed within the Buddhist traditions (Kabit-Zinn, 2006:145). It is from here that it was introduced into clinical settings. This article will contribute to this movement by examining if mindfulness is relevant for young people who had engaged in harmful sexual behaviours and by extension Social Work? The word 'engaged' used here signifies that these young people were the authors of sexual abuse to varying degrees of severity. This question was first explored through a thesis, supervised by Dr. Eilís Ward of the School of Political Science and Sociology at NUI Galway, which was written as part of their Masters in Social Work programme. Thus, this article will take much of its inspiration from this thesis.

The thesis in question was written in the context of a second year placement during that Masters. This article will begin by exploring the author's own interest in mindfulness and Buddhism. This interest in turn facilitated the mindfulness practice with this group of young people. The methodology used in the thesis, and thus this study, will then be discussed. This will be followed by an outline of the results of the study. In concluding, we will explore the possible implications of these findings for social work. We will also be looking at some thoughts on the wider context of Buddhism and social work.

Social work in Ireland and that of other countries can be traced back to the religious institutions of the 19th century (Brenner et al, 2004; Kearney and Skehill, 2005). Within these institutions, social work found support and direction to develop into the profession it is today. Yet in the early 20th century, in striving to professionalise itself, social work shed these religious and spiritual roots (Brenner et al, 2004). More recently, reconnecting practice with spirituality has come into focus (Brenner et al, 2004). As Buddhism spread through the world, it has been reinterpreted by other cultures. This is also true in the Western world. It can be seen through the adoption of mindfulness for clinical applications. This idea grew the author's interest in the possible benefit of an interaction between Buddhism and social work. The author tested this suspicion by facilitating a mindfulness practice which consisted of six sessions of ten minute concentrating mindfully on the breath. The mindfulness practice was conducted with a group of young people who have engaged in sexually abusive or harmful behaviour. We will now shed more light on what mindfulness is and why it may be relevant for young people.

Mindfulness

In Buddhism, mindfulness is viewed as an integral part of the eight fold path leading to the end of suffering, the ultimate aim of Buddhist teachings. The eight fold path is the practical guideline to ethical and mental development with the goal of freeing the individual from attachments and delusions. It ultimately leads to understanding the truth about all things. Together with the Four Noble Truths, it constitutes the gist

of Buddhism. Mindfulness underlies all streams of Buddhist meditative practice (Kabit-Zinn, 2003:146). It has been described by Buddhism as a way of guiding the senses through the complexity of the world; "repeatedly recollects awareness into the present, remembering oneself so that one's actions are purposeful and appropriate, grounded in time and place" (Sujato, 2006:78).

Furthermore, it is the view of Buddhism that, through the process of mindfulness, we slowly become aware of what we really are. Keeping in mind the importance of awareness, it is important for us to examine a significant aspect of the Buddhist teachings in order for us to be able to examine its relevance later in the article. The notion of Nonduality is believed to be a core Buddhist teaching and is a notoriously difficult concept to define (Scarbourough, 2011). Nonduality, put simply, is the rejection of unchanging substances, fixed essences, inherent existences or fixed identities, be that in subject or in object, concept or things (Scarbourough, 2011). Building upon this, nonduality is the assertion that there is no absolute independence between things, concepts or linguistic meanings.

One illustration of nonduality is that of the concept of anatta, or the "not-self" (Loy, 2008). Loy (2008) explains the not-self to mean that there is no unconditional self within our constructed sense of self. The Buddhists believe that "the self" exists as a pattern of behavioural responses, but not as a fixed unchanging self. This pattern is always in some degree of flux. While an individual is always in some sense, the same person, they are different now, than they were, for example, at age three. Their intellectual capacity, eyesight, memory and way of looking at the world will change with age. Tastes and opinions may change as well. While we follow a relatively enduring pattern, we are also constantly changing. Learning, developing, maturing, declining and changing depends on our situation.

Previously, mindfulness was a relatively unfamiliar concept in the Western culture (Kabat-Zinn, 1982). Kabat-Zinn (2000:239) suggested that mindfulness practice may be beneficial to people, in Western cultures. However, they may be unwilling to adopt Buddhist traditions or vocabulary. Thus, Western researchers and clinicians have introduced mindfulness practices into mental health treatment programmes independent of their religious and cultural origins (Kabat-Zinn, 1982, Linehan, 1993a). This has been termed universalism of mindfulness (Dellbridge and Lubbe, 2009:168). In Western literature, mindfulness has been described as "bringing one's complete attention to the present experience on a moment-to-moment basis" (Marlatt and Kristeller, 1999:68). Also as "paying attention in a particular way: on purpose, in the present moment and non-judgmental" (Kabat-Zinn, 1994:4).

Mindfulness was first introduced into health psychology by Jon Kabat-Zinn in the late 1970's. At the Massachusetts Medical Centre, he developed the hospital's Stress Reduction Clinic and mindfulness-based stress reduction (MBSR). MBSR was developed originally to treat those suffering from chronic pain (Kabat-Zinn, 1990). According to the literature, MBSR was received with great enthusiasm (Baer, 2003). Subsequently, it was offered in hundreds of hospitals across America and abroad (Baer, 2003). Due to the early success of MBSR, other mindfulness therapies and applications emerged. Mindfulness expanded to other symptoms and disorders, including depression, anxiety, borderline personality disorder, cancer side-effects, eating disorders and sexual dysfunction (Baer, 2003:125).

Following these successes, other interventions have sought to incorporate elements of mindfulness into their theories of working (King, 2013), illustrating their increased acceptances in clinical settings. One such example of this is Dialectical Behaviour Therapy (DBT). Another is Acceptance and Commitment Therapy (ACT). ACT is theoretically based in contemporary behaviour analysis (Hayes and Wilson, 1993). In using mindfulness in clinical areas, researchers have begun to understand its effects. We will now look more closely at these reported beneficial effects.

Reported beneficial effects

Researchers suggest that the ability to maintain a more mindful perspective on a day-to-day basis, even when under pressure, can result in more flexible, adaptive behaviour and self-management (Thompson and Gauntlett-Gilbert, 2008:396; Baer, 2003:129). The objective self-observation fostered by mindfulness is believed to allow one to recognise problematic situations before they escalate and examine potential coping strategies without lapsing to habitual patterns of response (Thompson and Gauntlett-Gilbert, 2008:398; Baer, 2003:129). In his review of the literature, Baer (2003) identified several key themes that appear to be the beneficial effects of mindfulness. Kabat-Zinn (1982) explains that in his original study with chronic pain sufferers, prolonged exposure to the sensations of chronic pain, in the absence of catastrophic consequences, might lead to desensitisation. He believes there could be similar mechanisms at work in other studies (1992). Sustained, non-judgmental observation of anxiety-related sensations, or other conditions, without attempts to escape or avoid them, may lead to reductions in the emotional reactivity typically elicited by anxiety symptoms (Kabat-Zinn, 1992; Baer, 2003:128).

Similar to this idea of desensitisation, is that the practice of mindfulness may lead to changes in thought patterns, or in attitudes about one's thoughts. Authors describe mindfulness training as developing the ability for patients

to understand that one's thoughts and feelings are "just thoughts," rather than accurate reflections of truth or reality, and do not necessitate escape or avoidance behaviour (Kabat-Zinn, 1982; 1990, Linehan, 1993a; 1993b; Baer, 2003:129; Monshat et al, 2012:4). Authors also cite relaxation as one result of mindfulness training. These authors note that meditation often induces relaxation, which may contribute to the more effective management of various disorders (Baer, 2003:130; Delbridge and Lubbe 2009:169). Indeed the Buddhists believe that relaxation is not just a consequence of mindfulness, but is the catalyst which allows the development of the other aspect of mindfulness (Hanh, 1999).

The research says that through the processes outlined above, the patient ultimately also learns acceptance (Baer, 2003; Monshat et al, 2012; Delbridge and Lubbe 2009). All of the treatment programmes reviewed in the thesis include acceptance of pain, thoughts, feelings, urges, or other bodily, cognitive and emotional phenomena, without trying to change, escape, or avoid them. Kabat-Zinn (1990) describes acceptance as one of several foundations of mindfulness practice. DBT provides explicit training in several mindfulness techniques designed to promote acceptance of reality. Thus, it appears that mindfulness training may provide a method for teaching acceptance skills (Baer, 2003; Monshat et al, 2012; Delbridge and Lubbe, 2009). Having examined the reported benefits of mindfulness with adults, it now seems appropriate to begin to focus on the research question, if mindfulness is relevant for young people who had engaged in harmful sexual behaviours, by examining these benefits with young people.

Beneficial effects for young people

Monshat and his colleagues (2012) recently reviewed the literature on mindfulness training and young people and identified how mindfulness training may affect children and young people. Their results were consistent with previous qualitative studies of young people and high-quality studies involving adults (Monshat et al, 2012). They identified the effects on the young people as being firstly an attainment of a sense of relaxation or calm (Monshat et al, 2012:129; Delbridge and Lubbe 2009:169). Also, the development of an ability not to be controlled by one's emotions, directly or where a sense of agency in specific situations was created by engaging with a particular mindfulness practice e.g., bringing attention to the breath (Black et al, 2009:538; Monshat et al, 2012:5; Delbridge and Lubbe 2009:174). Finally, they noted an attainment of a more considered stance towards oneself and others, as expressed as a shift in perspective or a greater awareness and acceptance (Monshat et al, 2012:5; Delbridge and Lubbe, 2009:171).

Another important outcome of mindfulness, discussed earlier, is a person's ability to objectively observe themselves. This allows someone to recognise problematic situations before they escalate and examine potential coping strategies without lapsing to habitual patterns of response. In this way, impulsivity is reduced (Hooker and Fodor, 2008:86; Baer, 2003:129). This self-regulation of attention, cognition, emotion and behaviour may be particularly beneficial for individuals with difficulties in these areas (Haydicky et al, 2012). Having examined mindfulness and its possible relevance for young people, we are now equipped to examine more specifically the group of young people who have engaged in sexually harmful or abusive behaviour.

Younge people who have engaged in sexually harmful or abusive behaviour

There has been limited academic attention given to working with this group of young people in Ireland. To clarify, the term 'young people' was defined, in the thesis, as "the time of life that is neither childhood nor adulthood" (King, 2013:8). This definition is coherent with the agencies ethos. They believe in giving young people "the dignity and respect of acknowledging them as young adults, and not just children" (King, 2013). In examining the literature on the causes of sexual abuse, the reader will then be better guided to understand the approaches used by the agency in working with these young people. It is worth noting that, despite the literature looking at the cause of sexual abuse being based on adults, much of this research is applicable to young people too (King, 2013).

In the literature, there are three prominent models of understandings sexual abuse. Finkelhor's (1984) Precondition Model of Child Sexual Abuse, Hall and Hirschman's (1992) Quadripartite Model and Marshall and Barbaree's Integrated Theory (1990). Ward and Siegert (2002) synthesised these theories by explaining that Finkelhor's theory neatly links offenders' psychological vulnerabilities with the offence process. Adding that, Hall and Hirschman comprehensively address the issue of typology. They finish by stating Marshall and Barbaree convincingly describe the way developmental adversity can result in vulnerability to sexually abuse a child (2002). These theorists share an understanding that a satisfactory explanation of child sexual abuse must be multi-factorial (Ward and Siegert, 2002). This multi-factorial understanding then required the agency to take a multi-factorial approach.

Ward and Stewart (2003:78) criticised the concept of 'criminogenic needs' of ignoring more 'basic human needs' that underlie optimal personal fulfilment. Criminogenic needs are characteristics that are potentially changeable and have a demonstrated relationship with recidivism (Hawkins et al, 2012). They argued that attaining the basic 'goods' of "friendship, enjoyable work, loving relationships, creative pursuits, sexual satisfaction, positive self-regard, and an intellectually challenging environment" should be the primary goals of an offender's rehabilitation (Ward and Stewart, 2003:142). Achieving these goals will result in reductions in criminogenic needs. Subsequently, Ward

and his colleagues have expanded on this with what they call 'The Good Lives Model' through various publications (Andrews et al, 2011). 'The Good Lives Model' has been described as a positive, strengths-based and restorative supplement to the traditional Risk-Need-Responsivity Model of offender rehabilitation (Ward and Maruna, 2007; Ward et al, 2007; Ward and Stewart, 2003). In addition, it has been presented as a supplement to the Risk-Need-Responsivity Model in the particular areas of offender motivation. As well as personal identity (Ward et al, 2007:204) and a firmer proponent of human rights than Risk-Need-Responsivity (Ward et al, 2007; Andrews et al, 2011).

With this brief understanding of the models of interventions, we can now move on to looking more specifically at the intervention model featured in the thesis. The intervention model was that of the community-based treatment programme in the North Side of Dublin, Ireland, called NIAP (North-Side Inter-agency Project). At the time of the thesis being written, there were only three treatment programmes for young people who have engaged in sexually abusive and harmful behaviour in Ireland. NIAP is a community-based treatment programme for young people who engage in sexually harmful behaviour and for their parents and carers and it provides a holistic service where by a young person attends a weekly therapeutic programme for two years approximately. which includes a combination of group, individual and family work. They employ an adaptation of the good lives programme previously introduced. Their adaptation of 'the good lives' programme is similar to the literature described above and is currently under evaluation. The overall aim of the multi-disciplinary agency is to prevent further sexual abuse by children and young people. This is achieved by enhancing the young peoples' capabilities to attain primary human goods and in doing so; reduces their chances of committing further crimes (Ward et al, 2006). It was during the author's placement in this agency's treatment programme that he was able to capitilise on his interest in mindfulness and thus formulate the research question examined in the thesis.

The thesis examines specifically the views of professionals on the research question: 'Is there potential for the practice of mindfulness to be helpful for young people who have engaged in sexually abusive or harmful behaviour?' Unfortunately due to ethical restrictions, it was not feasible to interview the young people directly on this question. However, as this article explores, the views of the professionals revealed some very intriguing results nonetheless. This was researched through the use of semi-structured interviews, with professionals working with these young people. The professionals consisted of social workers and clinical psychologists. They were interviewed because of their proximity to the young people as well as the previously mentioned ethical restrictions. A field diary was also kept and an interview was conducted with Dr. Tony Bates to further support the study's findings. Dr. Bates has 30 years of experience working in mental health, and is the founding Director of Headstrong – The National Centre for Youth Mental Health, in Ireland and an author of several bestseller books on depression and mindfulness.

The findings of that study were that there is a unique potential for mindfulness to be helpful for young people who have engaged in sexually abusive or harmful behaviour. This finding was supported by the literature at the time. The thesis discussed the ability of mindfulness to: relax, aid the young people in transitioning from one situation to another, and give them a potential skill to aid in navigating and regulating their thoughts and emotions more effectively. These benefits do not seem to be currently available in any other method of working with young people who have engaged in sexually abusive behaviour in Ireland or abroad at the time of the thesis being written (King, 2013).

Several recurrent themes emerged from the interviews, the first of which was relaxation. An interviewee commented that "on a physiological level, the breathing is slowing them down, slowing their heart rate down, they are slowing down physically and mentally" (King, 2013). As indicated by the literature review of the thesis, relaxation is a theme that is consistent with the research (Monshat et al, 2012:129). As was mentioned in the thesis, Buddhists believe that relaxation is the catalyst which allows the development of the other aspect of mindfulness (Hanh, 1999).

The second theme spoken about by the interviewees was emotional regulation. All of the interviewees in the study spoke about the use of mindfulness to aid the young people with navigating through their emotions. As we have seen from the literature review, this appears to be a consistent problem for young people (Seinberg, 2010). The third theme that emerged is connected to emotional regulation. Comments about the ability of mindfulness to help a young person transition more healthy from one situation to another, were discussed in the thesis; "useful…as a nice bridge for them…helped them transition into the rest of their day" (King, 2013).

The next theme discussed by the interviewees was the distinctiveness of mindfulness. An interviewee commented that mindfulness is "simple, common sense, it's not rocket science, but people have wrapped it up and packaged it" (King, 2103). As has already been illustrated, the previous themes discussed by the interviewees, Tony Bates and the wider literature suggest that there is something different and unique about mindfulness. Baer (2006;130) believes that, unlike other treatments, mindfulness does not include the evaluation of thoughts as rational or distorted, or systematically attempt to change thoughts judged to be irrational. Instead, participants are taught to observe their thoughts, note their impermanence, and to refrain from evaluating them (Baer, 2006;130).

We have seen so far how the mindfulness might benefit the young people. Finally, some interviewees also commented on how practitioners may also gain from some of the same benefits of mindfulness. One interviewee spoke about the potential benefits of loving-kindness meditation. According to him, this meditation helps to develop positive feelings towards oneself and then ultimately towards others around you;

> "loving-kindness is linked into the mindfulness in the sense that there are a lot of negative thoughts in there, you start off developing loving-kindness for yourself, letting go of all the self-criticisms, then they move on to developing loving-kindness for someone you're close to, someone you're ambivalent about, and someone you have problems with, all about a core understanding that everyone wants to be happy" (King, 2103).

This interviewee believed that "the better you feel about yourself and the better you feel towards others". He explained how he felt that his background in meditation allowed him to be more in tune with his work and the people he works with "genuine respect for other people, if I've to write a letter, I try to be as clear as possible, but also deliver it in a compassionate way" (King, 2013). Following from this, observations from the field diary commented that Buddhist values reflected the values of the helping professional, specifically for him as a social worker. Therefore, comments from the interviewees appear to confirm this premise as well as the work of Turner (2009). This same interviewee also described the benefits of emotional regulation for a professional "when working in crisis, it can overwhelm you, then you respond in the chaos, the grounding side of meditation…not getting pulled into the chaos" (King, 2013).

A second point that was spoken about by the professionals, in the thesis, is how mindfulness might allow them to transition between situations. One interviewee described it as; "there's transitions that you need to make in mental health…I felt its ability to help you transition was one of the more attractive, useful things about it" (King, 2013). In this same sense, another participant commented that mindfulness has "potential to be really positive in all of our lives…it's good for all of us to stop and take a moment" (King, 2013).

Interestingly, during the author's time as a practicing social worker in England, he facilitated a mindfulness group with his social work colleagues. This mindfulness group used the same mindfulness instructions as that used with the group of young people in the thesis. The social workers gave similar informal feedback following their mindfulness practice. They too commented on the potential benefits of mindfulness in terms of transitioning and relaxation allowing them to be more connected to their work and therefore the people they worked with.

This discussion now leads us to another interesting point that emerged from the thesis reflecting the deeper aspects of Buddhist teachings. This discussion now leads us an interesting aspect that had emerged from this study, that is the unintended effect that mindfulness practice had on the professionals.

As previously mentioned, Western researchers and clinicians have introduced mindfulness practices into mental health treatment programmes independent of their religious and cultural origins (Kabat-Zinn, 1982; Linehan, 1993a). This brings us back to the concept of nonduality, previously explained. That is to say that the experience of the mindfulness of these young people also had an experience on the professionals. The Buddhists would understand this as everything being of one nondual consciousness. Following on from this line of thought, we can understand that the practitioners' experience of observing the young people who in turn were experiencing the practice of mindfulness did logically lead to them experiencing mindfulness. As the concept of nonduality would explain, the practitioners' experience and the young people's experience were in fact one "experience" as they were both connected. This point would appear to hint at a deeper and perhaps wider unintended effect of mindfulness.

Conclusion

Based on what has been explored in the thesis and this article, mindfulness holds a unique potential for aiding young people who have engaged in sexually abusive or sexually harmful behaviour and the interventions. This would seem to be especially true for the Irish model discussed in this article. The ways in which it would appear to be beneficial include: relaxation, emotional regulation and transitioning.

Further from this, the potential benefits for practitioners was also discussed. The benefits for them as individuals and how this may positively impact on their practice in the areas of relaxation, emotional regulation, being in tune with the work and transitions between different aspects of the job.

Finally, from a wider perspective the indirect effect that this mindfulness practice had on the practitioners highlights the relevance of the concept of nonduality. It is important to note this is in spite of the use of the concept termed universalism of mindfulness (Dellbridge and Lubbe, 2009;168). That is to say mindfulness independent of its religious and cultural origins (Kabat-Zinn, 1982;Linehan, 1993a). As previously discussed, the experience of the mindfulness of these young people also had an impact on the professionals' experience. Put simply, mindfulness has relevant benefits for all parties concerned reitierating the quote from thesis title: "Mindfulness is useful everywhere" Buddha.

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The [Re]Turn to Relationship-based Social Work

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Abstract

Renewed interest in relationship-based practice can be understood as an attempt to reclaim social work from the imperatives of managerialism and ensuing procedurised, risk-adverse approaches to practice. This article argues that while procedures and protocols have their place, they should not supersede the foundational elements of social work, namely the social work relationship and sensitivity to social contexts. This article traces the origins of relationship-based practice and examines contemporary applications of the approach. The core psychodynamic concepts of containment, transference and counter transference are outlined and the therapeutic possibilities of working more explicitly with these concepts in social work practice are discussed. The potential of relationship-based practice in addressing the impact of people's social circumstances on their emotions and behaviours is considered. Finally, the benefits of extending a relationship-based approach to wider networks of practice relationships are explored.

Key Words: Relationship-based practice, reflective practice, therapeutic processes, containment, transference, counter transference, defences, practice relationships.

Introduction and Context

For over two decades, health and social services in western societies have been shaped by neo liberal policies and ensuing managerialism, resulting in financial austerity measures, contracting public services and growing reliance on private care. While social workers strive to navigate, mitigate and at times subvert the systems they work within, neo liberal policies have produced a hostile climate for the practice of value-based social work. This article traces a renewal of interest in relationship-based practice and considers how it is applied in contemporary social work.

It has been suggested that the [re]turn to relationship-based practice may be partly understood as a counterbalance to burgeoning administrative responsibilities and procedurised, risk-adverse practice that have become features of service provision (Wilson et al, 2008). Procedures and protocols, while important, need to be integrated as part of a comprehensive approach underpinned by ethical principles and theoretical perspectives. Cooper and Lousada argue

> Structures, procedures and protocols may be necessary, but they are not sufficient conditions of good practice. They are surface instruments, capable of guiding us and organizing us towards the relevant point of contact with the deeper, more complex and ambiguous realities with which we need to engage…
>
> (Cooper and Lousada, 2005:153)

Drawing on Gupta and Blewitt, Wilson et al suggest 'whilst they have their place, managerialist practice approaches are incomplete responses to the conditions they are seeking to address……[and run] the risk of being insensitive to and inappropriate for an individual's circumstances' (Wilson et al, 2008:5). Furthermore, there is a risk that managerialist practice becomes 'an emotionally-distanced way of managing people in need' (Woodhouse and Pengelly cited in Wilson et al, 2008:7). Major child protection inquiries and reviews such as Gibbons et al, 2010 and Munro, 2011 stress the importance of meaningful engagement with primary clients. There have also, been calls in the social work literature to re-balance towards direct work with service users (Parton, 2008; Featherstone et al, 2011) and to embrace forms of relational (Broadhurst and Mason 2012) and relationship-based practice (Lefevre, 2008; Ruch et al., 2010).

Service users have long-since attested to the significance of a meaningful relationship with their social worker (Mayer and Timms, 1970; de Boar and Coady, 2007; Beresford, Croft and Adshead, 2008; Howe, 2008; Doel, 2010). In an Irish study on service-user experiences in the context of child protection social work Buckley, Carr and Whelan report

> As in previous studies, the data showed how the development of good relationships between workers and service users could compensate for the harsher aspects of involvement with child protection. In addition, this study demonstrated a high level of discernment on the part of service users, highlighting their expectation of quality standards in respect of courtesy, respect, accountability, transparency and practitioner expertise.
>
> (Buckley, Carr and Whelan, 2011:101)

The findings of a UK study on service user and carer expectations of social workers, show that people value

> …understanding the intentions and purposes of the worker; contributing to the work of the service; receiving help speedily; the worker's ability to respond to feelings not always expressed; the worker's concern and attention, even if change is not possible and the worker's ability to exercise care even when exercising control.
>
> (Doel, 2010:199-200)

It is clear from service user research that regardless of the practice context, the quality of the social work relationship has been a central feature of social work across time. It seems important therefore that social work would be more explicit about how a relationship-based approach is applied in practice.

What is Relationship-based Practice?

Although none of the key authors on relationship-based practice (Howe, 1998; Sudbery, 2002; Trevithick, 2003; Ruch, 2005, 2010; Wilson et al, 2008; Cooper, 2014; Megele, 2015) offer a definitive definition there is general agreement that relationship-based practice focuses on the connectedness of people's internal and external worlds and is based on an understanding of human behaviour as complex, integrating emotional, rational and unconscious dimensions. In addition, equal attention is given to issues arising for the worker and the worker's interactions in the practice situation.

> As a social 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. By developing this ability to understand holistically the service user's and your own responses to a specific situation you will ensure you are acting in the service user's best interests.
>
> (Wilson et al, 2008:7)

These authors suggest that relationship-based practice brings together three aspects of human functioning that are often polarised namely

- conscious and unconscious behaviours (for example disruptive behaviour may be an unconscious effort to deflect emotional distress);
- cognitive and affective responses (recognising if service users'/professionals' behaviours are overly cognitive/rational or overly emotional, and the need for balance and integration);
- personal and professional selves (each social work encounter is unique to the individuals involved and relationship dynamics are the combined result of their individual characteristics within a professional context)

(Wilson et al 2008:8-11).

Relationship-based Practice and Psychodynamics: Integrating Therapeutic Processes

Relationship-based social work provides a framework to respond therapeutically to distress, anger, guilt, regret and other difficult emotions which is arguably an underdeveloped capacity in social work. Sudbery (2002) points to the limitations of models of social work practice and of broader public service that privilege rationality and logic over emotion. He emphasises that responsiveness to people's emotional needs is a hallmark of an effective service

> …a core component of social work is the ability to respond to people's emotional needs, to their impulse for emotional development, and to the difficulties they experience in forming and maintaining relationships……the purpose of social work is empowerment, the approach chosen must be participative and the starting point (as well as the continuing medium) is the social worker's response to someone making demands, in distress, requiring service…..it is the quality of the social worker's response which determines the effectiveness of service.
>
> (Sudbery, 2002:150-151)

Trevithick (2003) describes the process through which the therapeutic potential of relationship-based practice may be realised

> …[relationship-based practice] may involve providing a 'corrective' or 'reparative' emotional experience - that is, a more intense and therapeutic use of the relationship where this is needed to help individuals to come to terms with, and hopefully to overcome, the impact of failed, abusive and abandoning relationships, or separations or traumatic experiences due to other causes…
>
> (Trevithick, 2003:168)

Holding and containing anxiety are particularly important in times of transition or crisis (Trevithick, 2003) and relationship-based practice facilitates this work. According to Ruch 'the underlying and all-pervasive feature of relationship-based practice is the acknowledgement and management of anxiety (practitioners and clients)….' (Ruch, 2005:114-115). In working with emotions and ensuing behaviours in the context of uncertainty and distress, social workers practicing from a relationship-based perspective are mindful of the core psychodynamic concepts of containment, transference and counter-transference.

Containment

Containment is a concept developed by Bion, a psychoanalyst who believed feelings of anxiety, produced in unpredictable situations could overwhelm the capacity for cognitive processing of experience. Bion (1962)

applied this concept to the relationship between therapist and client, proposing that the therapeutic relationship can act as a 'container' for unmanageable feelings, lessening the overwhelming effects of anxiety-producing situations and allowing the person to integrate unmanageable feelings into thought processes. Like Winnecott's concept of holding, the concept of containment emerged from object relations theory and views the clinician/client relationship as creating a holding environment similar to the environment of safety and security provided in the bidirectional mother/child relationship. The containing relationship is seen as mirroring positive parenting and also as potentially reparative when past relationships have been difficult or destructive (Trevithick, 2003; Goldstein et al, 2009). Goldstein et al suggest that every therapeutic relationship is a dynamic encounter between two people and is also subject to a myriad of contextual influences acknowledging that 'race, ethnicity, culture and other diversity factors add layers of external and internal meaning to the understanding of holding and containment' (Goldstein et al, 2009: 161). Trevithick describes the containment process in the practice setting

> ….talking to someone who has the ability to listen, to empathise, to take in and to bear the worries being expressed, and the ability to come alongside the individual in ways that communicate an understanding and give the sense that the person is not alone. The final stage of this process involves offering back the concerns to the anxious person but in a modified form - where the major anxieties are managed but are altered so that they no longer carry the same 'sting' or sense of turmoil or anguish. This enables 'natural' growth processes to reassert themselves…..
>
> (Trevithick, 2003:171)

Transference

Transference is understood to be a re-experiencing of feelings from the past in the context of a current relationship. Trevithick (2003) explains it as follows 'although feelings are located in the present, they often have an earlier unconscious (unaware) aspect and can involve transferring of positive feelings (trust, affection) towards others or involve transferring more hostile feelings (mistrust, dislike)…' (Trevithick, 2003:170). Sudbery traces these feelings from the past, to experiences of being parented or cared for '….transference refers to the propensity of a helping relationship in the present to have echoes of the situation when the user of the service was a child and needed assistance or care from their parent' (Sudbery, 2002:153).

If the worker is relating with genuine care and integrity as part of a reliable, predictable arrangement and the other person receives acceptance in response to re-emerging residual feelings and needs, it becomes possible for difficult feelings to dissipate, contributing to the person finding a resolution that was not available in the past.

Sudbery highlights the importance of self-awareness and containment of the worker's own emotions in order to facilitate these psychosocial processes for the service user '...it remains important for the social worker to be emotionally 'quiet' and receptive if the transference is to emerge as a medium for emotionally developmental work' (Sudbery, 2002:154)

Counter-transference

The significance of the reactions and role of the worker can be further understood with respect to the related concept of counter-transference which encompasses both being impacted by the emotions of the other person and the worker's own emotional reactions to the issues, emotions or behaviours emerging in the interaction. Trevithick (2003) clarifies what is understood to be counter-transference and highlights the need to distinguish feelings arising from our own past from those related to the experiences of the other person.

> Counter-transference reactions, in so far as they correctly mirror another person's thoughts and feelings enable us to experience some of the emotions that another person might be feeling or thinking. In social work literature, these reactions are sometimes described as empathy or use of intuitive skills. However when attempting to understand transference and counter-transference reactions, we run the risk that our own unconscious, unresolved fears and fantasies from the past may enter the picture to blur reality and our accurate reading of the situation
>
> (Trevithick 2003:170)

Sudbery addresses the management of the worker's countertransference during and after meetings with service users.

> …(the worker's) experience in the present contains echoes - reawakenings or re-experiencing - of the past, which may not be related to the present reality of the client they are assisting…..The countertransference feelings may be understood quickly by the worker in the social work interaction, or…may have to be 'held' (neither suppressed or acted out) until they receive appropriate attention in supervision…..[which] teases out the different components - those which purely relate to the worker and those which provide otherwise unavailable insights about the client's communication…
> The ability to do what is right in the social work role requires the ability to enter into troubled and disturbing subjective experiences whilst thinking, making judgments and behaving appropriately in the more objective world of outside reality and organizational procedures.
>
> (Sudbery, 2002:155)

Working with distress makes significant emotional demands of the worker and if this is not properly

addressed, conscious or unconscious defence mechanisms can include the de-personalising of the worker-client relationship or a retreat to procedurised practice and a focus on tasks (Preston-Shoot and Braye, 1991; Hughes and Pengelly, 1997; Sudbery, 2002; Ruch, 2005). Good supervision, focusing on the dynamics of the social work relationship is essential in avoiding defensive practice. It allows us to recognise, monitor, clarify and understand transference and counter-transference reactions and to decide how best and when to translate this awareness into practice (Howe, 1998; Sudbery, 2002; Trevithick, 2003; Wilson et al, 2008). Relationship-based practice therefore builds capacity to work therapeutically through the conscious use of the core psychodynamic concepts of containment, transference and counter transference, in practice.

Relationship-based Practice and Reflective Practice

Wilson et al (2008) propose reflective practice, based on situated, holistic thinking (Fook 2002) as a way to put a relationship-based model into effect in practice. The reflective process allows the social worker to modify and develop their approach in accordance with the needs of the person with whom s/he is working. The reflective practitioner actively engages with theory according to the emerging insights and needs in the practice situation rather than applying ready-made solutions (Thompson, 2009). Wilson et al explain the reflective practice process in relationship-based social work as follows

> Schon's reflection-on-action and reflection-in-action can be likened to the 'conversations in our heads' that happen when social workers engage in practice. Often, whilst relating to service users, social workers are thinking or feeling things that are pertinent to the encounter but they fail to articulate them…These feelings….can be experienced as an internal conversation that keeps cutting across the external conversation that is 'focusing on task'….A potentially more informative, relationship-based and reflective response would be to articulate the feelings - the confusion and uncertainty, for example - being experienced. It is often the case that in doing so the service user can articulate their own affective responses - their confusion and uncertainty, perhaps - and a more real and productive conversation and relationship can develop.
>
> (Wilson et al, 2008:13-14)

An example of this approach might be a conversation between a social worker and a person who is homeless, whereby each option explored is discounted as unsuitable and the worker feels increasingly helpless and hopeless. Following a relationship-based practice approach, these feelings would be understood as counter transference and used as a source of information as to the potential feelings of the service user, which can then be checked out with him/her. In addition the social worker becomes aware of practice issues and feelings that s/he finds difficult for example feeling powerless and de-skilled. These experiences and their impact can subsequently be explored further in supervision. This promotes social workers' understanding of their own responses and Wilson et al argue, reduces the need for defensive strategies in order to survive professionally. It also enables social workers to be emotionally available to service users who may have varying degrees of awareness in relation to the issues underpinning their responses in a given situation (Wilson et al, 2008).

Social and Cultural Contexts

Trevithick identifies the socio-political environment as the source of many problems in people's lives. She discusses the interplay of negative life experiences and defensive behaviours produced to protect against anxiety and perceived threats. As a way forward Trevithick recommends working with people to reduce their exposure to negative experiences and instead to identify and engage in experiences which generate more positive feelings. Again the therapeutic relationship is seen as significant in 'providing a setting that gives confidence…' in moving towards fulfilment (Winnicott, 1975 cited in Trevithick, 2003:172). Trevithick links this work to a strengths perspective which restores hope and builds people's capacity to move forward in their lives (Trevithick, 2003:171-172). Similarly, Saleebey describes a collaborative social work relationship as a basis for a strengths approach

> In a strengths approach, how social workers encounter their fellow human beings is critical. They must engage individuals as equals. They must be willing to meet them eye to eye and to engage in dialogue and a mutual sharing of knowledge, tools, concerns, aspirations, and respect. The process of coming to know is a mutual and collaborative one. The individuals and groups the profession assist also must be able to "name" their circumstances, their struggles, their experiences, themselves. Many alienated people have been named by others - labelled and diagnosed- in a kind of total discourse. The power to name oneself and one's situation and condition is the beginning of real empowerment.
>
> (Saleebey, 1996:303)

Networks of Practice Relationships

The quality of wider practice relationships for example relationships with carers is central to effective relationship-based social work. Partnerships with service user communities and organisations provide a platform for advocacy on issues of rights and social justice, facilitate development of resources and keep practice aligned with people's lived experiences. The development of inter-professional and inter-agency relationships is integral to providing a comprehensive response to people, particularly to people with complex needs. Hudson alludes to negativity in the literature on inter-professional practice arising from the differential status of professionals, professional identity and territory and different patterns of discretion and accountability (Hudson, 2002 cited in Wilson et al, 2008:4000). Wilson et al also identify fundamentally different knowledge bases as a key division between social workers and many other disciplines. Social workers they argue work from a humanist tradition which can be at variance with the technical-rational scientific knowledge base of many of the other disciplines in healthcare. In addition to initiatives to resolve these differences at organisational and inter-professional levels, Wilson et al suggest that tensions can be addressed at the interpersonal level by extending principles and practices of relationship-based social work to relationships to the work environment (Wilson et al, 2008: 402-408).

Conclusion

No one theory will adequately capture the complexity and singularity of someone's life. Our constructions and conceptualisations of others, sometimes formed to serve particular interests (e.g. to fit within professional assessment categories or meet admission criteria of a service) may be at best partial representations and at worst may not be recognisable/acceptable to the people we intend to help. If instead, we base our practice on a responsive, caring relationship we will be more reticent in labelling someone's experience and collaborative in our understanding, describing and addressing issues that emerge.

Relationship-based practice alerts us to the complex emotional dynamics that are inevitably part of social work interventions. In combination with a reflective practice approach it provides a framework and skill set to work with the emotional components of practice. In extending a relationship-based approach to all professional relationships, relationship-based practice is understood as integral to how social work is practiced rather than merely one of many practice approaches

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The Assisted Decision-Making (Capacity) Act 2015: What it is and how it matters to health and social care professionals

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Abstract

The Assisted Decision-Making (Capacity) Act 2015 was signed by President Higgins in 2015 and scheduled for commencement in 2016. The legislation places the 'will and preferences' of people with impaired mental capacity at the centre of decision-making relating to 'personal welfare' (including healthcare) and 'property and affairs'. Capacity is 'construed functionally' and interventions must be 'for the benefit of the relevant person'. The legislation outlines three levels of decision-making assistance: 'decision-making assistant'; 'co-decision-maker' (joint decision-maker); and 'decision-making representative" (substitute decision-maker). There are also procedures relating to 'enduring power of attorney' and 'advance healthcare directives'. While the 2015 Act is considerably more workable than the 2013 Bill that preceded it, it will still involve a great deal of complex decision-making by persons with impaired mental capacity, their families, health and social care workers (including social workers), and judges.

Key Words: Mental health, Mental capacity, Psychiatry, Social work, Legislation, Human rights

In December 2015, the Assisted Decision-Making (Capacity) Act 2015 was signed by President Higgins with a view to commencement in 2016. The 2015 Act will have substantial implications for persons with impaired mental capacity, their families, and healthcare and legal professionals. It will replace the outdated Ward of Court system, which dates from the Lunacy Regulation (Ireland) Act of 1871. By way of contrast, the 2015 Act presents a range of measures and decision-making supports that will place the 'will and preferences' of the person at the centre of decision-making. This article discusses (a) the guiding principles of the new legislation; (b) decision-making supports it offers; (c) other matters covered in the Act (most notably 'enduring power of attorney' and 'advance healthcare directives'); (d) human rights aspects of these developments; and, finally, (e) possible implications for health and social care workers, including social workers (insofar as these can be ascertained at this time).

(a) Guiding Principles

The 2015 Act presents 'guiding principles' which include a presumption of mental capacity; someone shall not be deemed to lack mental capacity 'unless all practicable steps have been taken, without success, to help him or her'; someone shall not be deemed to lack mental capacity owing to an 'unwise decision'; every intervention must be necessary 'having regard to the individual circumstances of the relevant person' and must minimise restriction of rights and freedom of action; and every intervention must 'have due regard to the need to respect the right of the relevant person to dignity, bodily integrity, privacy, autonomy and control over his or her financial affairs and property'. Interventions must also 'be proportionate to the significance and urgency of the matter' and 'as limited in duration' as 'practicable' (Section 8).

The person himself or herself must be encouraged to participate in the process and the intervener must 'give effect, in so far as is practicable, to the past and present will and preferences of the relevant person', taking account of 'the beliefs and values of the relevant person' and 'any other factors which the relevant person would be likely to consider if he or she were able to do so', as well as the views of relevant others, the urgency of the decision and likelihood of recovery. The intervener must 'act at all times in good faith and for the benefit of the relevant person'.

As regards assessment of mental capacity, mental capacity is to be 'construed functionally' and 'shall be assessed on the basis of [the person's] ability to understand, at the time that a decision is to be made, the nature and consequences of the decision to be made by him or her in the context of the available choices at that time' (Section 3). 'A person lacks the capacity to make a decision if he or she is unable (1) to understand the information relevant to the decision; (2) to retain that information long enough to make a voluntary choice; (3) to use or weigh that information as part of the process of making the decision; or (4) to communicate his or her decision'.

(b) Decision-Making Supports

The legislation outlines three levels of decision-making assistance for those who need them: 'decision-making assistant'; 'co-decision-maker' (joint decision-maker); and 'decision-making representative" (substitute decision-maker). In the first instance, any adult 'who considers that his or her capacity is in question or may shortly be in question may appoint another person [a 'decision-making assistant'] who has also attained that age to assist the first-mentioned person in making one or more than one decision on the first-mentioned person's personal welfare [including 'healthcare'] or property and affairs, or both' (Section 10).

The decision-making assistant's role is to:

- 'Assist the appointer to obtain the appointer's relevant information';
- 'Advise the appointer by explaining relevant information and considerations relating to a relevant decision';
- 'Ascertain the will and preferences of the appointer on a matter the subject or to be the subject of a relevant decision and assist the appointer to communicate them';
- 'Assist the appointer to make and express a relevant decision';
- 'Endeavour to ensure that the appointer's relevant decisions are implemented' (Section 14).

The next level of decision-making support is the 'co-decision-maker" (joint decision-maker), who can, like the decision-making assistant, be appointed by any adult 'who considers that his or her capacity is in question', in order to 'jointly make with the first-mentioned person one or more than one decision on the first-mentioned person's personal welfare [including 'healthcare'] or property and affairs, or both' (Section 17). Unlike the decision-making assistant, the co-decision-maker makes the decision 'jointly' with the appointer, as well as advising the appointer, 'explaining relevant information and considerations', ascertaining the appointer's 'will and preferences', assisting and discussing, and making 'reasonable efforts to ensure that a relevant decision is implemented as far as practicable' (Section 19).

A number of documents are required in order to register a co-decision-making agreement, including 'a statement by a registered medical practitioner and a statement by such other healthcare professional of a class as shall be prescribed by regulations made under Section 31 that in their opinion (1) the appointer has capacity to make a decision to enter into the co-decision-making agreement, (2) the appointer requires assistance in exercising his or her decision-making in respect of the relevant decisions contained in the co-decision-making agreement, and (3) the appointer has capacity to make the relevant decisions specified in the co-decision-making agreement with the assistance of the co-decision-maker' (Section 21). It is not clear who these 'other healthcare professionals' are to be; presumably, social workers will be included.

The other mechanism for appointing a co-decision-maker involves the Circuit Court. To this end, any one of a number of persons can seek to apply to the Circuit Court in relation to a person's mental capacity, and, if a hearing proceeds, the Circuit Court 'may make one or both of the following declarations: (1) a declaration that the relevant person the subject of the application lacks capacity, unless the assistance of a suitable person as a co-decision-maker is made available' or (2) that the person 'lacks capacity, even if the assistance of a suitable person as a co-decision-maker were made available to him or her' (Section 37). In the event of declaration (1), the Court allows the person some time to appoint a co-decision-maker. Oversight of co-decision-making agreements will be organised by the director of the proposed Decision Support Service (Section 26).

The third form of decision-making support, 'decision-making representative' (substitute decision-maker), can be accessed if the Circuit Court makes declaration (2) following a hearing (the court can also make specific orders). The role of the decision-making representative is to 'ascertain the will and preferences of the relevant person on a matter the subject of, or to be the subject of, a relevant decision and assist the relevant person with communicating such will and preferences' (Section 41). As with the other levels of decision-making assistance, there are various 'restrictions' on decision-making representatives (Section 44) and oversight will be organised by the director of the proposed Decision Support Service (Section 46).

There are various other requirements and regulations for each of the three levels of decision-making assistance (and for 'enduring power of attorney' and 'advance healthcare

directives'), including, inter alia, qualifying and disqualifying criteria, mechanisms for support, oversight, review, complaints, objections, appeals and decisions by the Circuit Court. A legal aid scheme is outlined (Part 5, Chapter 7) along with transitional arrangements for current wards of court (Part 6). These are all key elements of the proposed framework, and much will depend on the development of rules, guidance, codes of practice and training programmes relating to all of these quite complicated processes.

(c) Other Matters Covered in the 2015 Act: 'Enduring Power of Attorney' and 'Advance Healthcare Directives'

The 2015 Act outlines detailed new procedures relating to 'enduring powers of attorney' (Part 7). According to the legislation, 'a person who has attained the age of 18 years (in this Act referred to as 'donor') may appoint another person who has also attained that age (in this Act referred to as 'attorney') on whom he or she confers either or both of the following: (1) general authority to act on the donor's behalf in relation to all or a specified part of the donor's property and affairs; or (2) authority to do specified things on the donor's behalf in relation to the donor's personal welfare or property and affairs, or both; which may, in either case, be conferred subject to conditions and restrictions' (Section 59). Such 'an enduring power of attorney shall not enter into force until

(1) the donor lacks capacity in relation to one or more of the relevant decisions which are the subject of the power, and (2) the instrument creating the enduring power of attorney has been registered'.

A number of documents need to be provided in order to create an enduring power of attorney, including a statement 'by a registered medical practitioner that in his or her opinion at the time the power was executed, the donor had the capacity to understand the implications of creating the power' and a similar statement 'by a healthcare professional of a class that shall be prescribed' (Section 60). This, too, will presumably include social workers. Similar statements are required for the variation or revocation of an enduring power of attorney (Section 73). Oversight lies again with the director of the Decision Support Service (Section 75).

The 2015 Act also outlines new procedures relating to 'advance healthcare directives' (Part 8). According to the legislation, an advance healthcare directive is 'an advance expression made by the person, in accordance with Section 84, of his or her will and preferences concerning treatment decisions that may arise in respect of him or her if he or she subsequently lacks capacity' (Section 82). A 'refusal of treatment set out in an advance healthcare directive shall be complied with if the following three conditions are met: (1) at the time in question the directive-maker lacks capacity to give consent to the treatment; (2) the treatment to be refused is clearly identified in the directive; (3) the circumstances in which the refusal of treatment is intended to apply are clearly identified in the directive' (Section 84).

'A request for a specific treatment', by way of contrast, 'is not legally binding but shall be taken into consideration during any decision-making process which relates to treatment for the directive-maker if that specific treatment is relevant to the medical condition for which the directive-maker may require treatment.' In addition, 'an advance healthcare directive is not applicable to life-sustaining treatment unless this is substantiated by a statement in the directive by the directive-maker to the effect that the directive is to apply to that treatment even if his or her life is at risk' (Section 85).

There is, however, a notable exception if the person's treatment is regulated under Part 4 the Mental Health Act 2001 (or the person 'is the subject of a conditional discharge order' under Section 13A of the Criminal Law (Insanity) Act 2006), under which circumstances the advance healthcare directive is not legally binding, except 'where a refusal of treatment' relates 'to the treatment of a physical illness not related to the amelioration of a mental disorder', in which case 'the refusal shall be complied with'.

A person who makes the 'advance healthcare directive' can appoint 'a designated healthcare representative [with] the power to ensure that the terms of the advance healthcare directive are complied with' (Section 88). In any case, 'an advance healthcare directive is not applicable to the administration of basic care to the directive-maker', where 'basic care' includes '(but is not limited to) warmth, shelter, oral nutrition, oral hydration and hygiene measures but does not include artificial nutrition or artificial hydration' (Section 85).

Finally, 'unless otherwise expressly provided, nothing in this Act shall be construed as altering or amending the law in force on the coming into operation of this section relating to the capacity or consent required as respects a person in relation to any of the following: (1) marriage; (2) civil partnership; (3) judicial separation, divorce or a non-judicial separation agreement; (4) the dissolution of a civil partnership; (5) the placing of a child for adoption; (6) the making of an adoption order; (7) guardianship; (8) sexual relations; (1) serving as a member of a jury' (Section 138). 'Nothing in this Act shall be construed as altering or amending the law relating to the capacity of a person to make a will' (Section 140), and appeal to higher courts is 'on a point of law only' (Section 141) (which seems restrictive).

(d) Human Rights Aspects

The Assisted Decision-Making (Capacity) Act 2015 represents a real effort to bring Irish capacity legislation into the modern era. It is especially welcome that the legislation emphasises supported decision-making for people with impaired mental capacity, and places the 'will and preferences' of the person at the very heart of all decision-making. The new legislation will bring Ireland more into line with the Convention on the Rights of Persons with Disabilities, adopted by the United Nations (UN) in 2006.

When the new Act is commenced, however, there are likely to be many operational issues to be ironed out, as well as some legal details to be clarified: it is, for example, somewhat difficult to identify the precise difference between a 'decision-making assistant' and 'co-decision-maker'. The much greater human rights issue, however, concerns the third level of decision-making support, substitute decision-making, as outlined in the 2015 Act. While the Convention on the Rights of Persons with Disabilities is not entirely clear on whether or not the UN regards substitute decision-making as permissible, the absence of a definitive prohibition on it suggests that models of substitute decision-making, such as that outlined in Ireland's new legislation, do not necessarily violate the Convention itself.

By way of contrast, the Committee on the Rights of Persons with Disabilities (2014; p.6), appointed by the UN under the Convention, explicitly rejects the idea of 'substitute decision-making' in all its forms:

'States parties' obligation to replace substitute decision-making regimes by supported decision-making requires both the abolition of substitute decision-making regimes and the development of supported decision-making alternatives. The development of supported decision-making systems in parallel with the maintenance of substitute decision-making regimes is not sufficient to comply with article 12 of the Convention' (which concerns 'Equal recognition before the law').

The Committee also rejects the use of the concept of 'mental capacity' in any form (let alone placing it at the heart of a new piece of legislation, as in Ireland):

'Mental capacity is not, as is commonly presented, an objective, scientific and naturally occurring phenomenon. Mental capacity is contingent on social and political contexts, as are the disciplines, professions and practices which play a dominant role in assessing mental capacity' (p.4).

The Committee notes that the 'functional approach' to assessing mental capacity (as in the 2015 Act) is 'often based on whether a person can understand the nature and consequences of a decision and/or whether he or she can use or weigh the relevant information', and concludes that 'this approach is flawed for two key reasons':

'(a) it is discriminatorily applied to people with disabilities; and (b) it presumes to be able to accurately assess the inner-workings of the human mind and, when the person does not pass the assessment, it then denies him or her a core human right - the right to equal recognition before the law. In all of those approaches, a person's disability and/or decision-making skills are taken as legitimate grounds for denying his or her legal capacity and lowering his or her status as a person before the law. Article 12 does not permit such discriminatory denial of legal capacity…' (p.4).

The Committee concludes that 'the provision of support to exercise legal capacity should not hinge on mental capacity assessments; new, non-discriminatory indicators of support needs are required in the provision of support to exercise legal capacity' (p.7). It is exceptionally difficult to understand what this means, and how decision-making supports are to be calibrated and accessed appropriately if the very idea of 'mental capacity' is to be abandoned entirely.

Overall, however, despite these issues and discussions, there is still little doubt but that the Assisted Decision-Making (Capacity) Act 2015 will bring Ireland into greater accordance with human rights standards, once it is commenced. As interpretations of the Convention on the Rights of Persons with Disabilities evolve over the coming years, and experience with the legislation grows, it is hoped that there will be greater clarity about many of the outstanding clinical, legal and human rights issues. For the moment, however, the greatest challenge probably lies in preparing both the public and relevant professionals in health and social care for the changes to come.

(e) Possible Implications for Healthcare Workers

Updated mental capacity legislation has been needed in Ireland for many decades (Kelly, 2016). One of the key challenges in the new paradigm under the 2015 Act will centre on the assessment of mental capacity in the first instance. There is a number of structured tools for assessing mental capacity, but reliable and valid assessments can also be performed by carefully considering each individual aspect of the specified legal criteria in turn (Hotopf, 2013). In this context, reliable and valid capacity assessments can be performed by focussing clearly and explicitly on the criteria set out in the 2015 Act; i.e. can the person 'understand the information relevant to the decision'; 'retain that information long enough to make a voluntary choice'; 'use or weigh that information as part of the process of making the decision'; and communicate the decision (Section 3).

While many practical aspects of the legislation are still being worked out, it is readily apparent that social workers will be deeply involved in all areas of its operation, in tasks ranging from educating the public to performing assessments of mental capacity in specific cases. Key challenges will include the complex decision-making required of not only of social workers, but also of persons whose capacity may be impaired, families, friends, other health and social care staff, Circuit Court judges, and the director of the proposed Decision Support Service. Training programmes have commenced for many of these groups and it is hoped that these will continue to be provided to new staff, and be underpinned by pragmatic guidelines and codes of practice.

Other challenges relate to the revised provisions for enduring powers of attorney and implementation of advance healthcare directives in complex, changing medico-social circumstances. Ideally, advance healthcare directives would form part of a broader model of advance care planning that would incorporate the flexibility required for unknowable future circumstances and advances in medical and social care, rooted in good therapeutic relationships.

The issue of logistics is critical. In 2013, there were 503,509 discharges from medical inpatient care in Ireland (Healthcare Pricing Office, 2014) and studies from other jurisdictions indicate that between 30% and 51% of medical inpatients lack mental capacity to make healthcare decisions at critical junctures (Owen et al, 2013; Bilanakis et al, 2014). In 2014, there were 17,797 psychiatric admissions in Ireland (Daly and Walsh, 2015) and studies from other jurisdictions indicate that 29% of psychiatry patients lack mental capacity to make healthcare decisions (Okai et al, 2007). In addition, there were over 27,000 people in nursing homes in Ireland in 2014 (BDO, 2014), and studies from other jurisdictions indicate that over 60% of these people lack mental capacity to make healthcare decisions (Christensen et al,1995). These are large numbers.

In theory, all of these people, as well as patients who lack mental capacity in primary care, will require supports under the 2015 Act. While it is likely that a decision-making assistant will be sufficient for most, it is not at all clear how many will require greater levels of support or how many Circuit Court hearings will be needed.

Clearly, the challenges are substantial. Not least of these is the need to balance the principle of autonomy with the principles of beneficence and mutuality, to result in healthcare that is consistent with the person's values and beliefs, and is also effective, humane and dignified. Such challenges are inevitable with any development of this magnitude which seeks to systematise many of the principles that already define good health and social care in Ireland, but will be placed on a more explicit footing with the 2015 Act. These are historically important changes, which need to be operationalised in an effective, empowering fashion, especially for particular groups, such as people with intellectual disability and comorbid mental disorder.

The latter group merits particular attention in the context of the 2015 Act. In 2006, A Vision For Change recommended that 'delivery of mental health services to people with intellectual disability should be similar to that for every other citizen' (Expert Group on Mental Health Policy, 2006; p.133). Services 'should be provided by a specialist mental health of intellectual disability (MHID) team that is catchment-area based. These services should be distinct and separate from, but closely linked to, the multidisciplinary teams in intellectual disability services who provide a health and social care service for people with intellectual disability'.

In 2016, over a century after Dr Conolly Norman, pioneering Resident Medical Superintendent at the Richmond Asylum (Grangegorman), warned that 'it is neither wise nor humane to neglect this class as they are neglected in this country', it is hoped that the 2015 Act will strengthen the agency of the intellectually disabled and their families, and assist in providing them with mental health care, as well as protecting and promoting their rights more broadly in a society that has ignored their voices too often in the past.

Conflict of Interest

There is no conflict of interest to declare.

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Values and Ethics Discourses in Irish Social Work: Which values do practitioners view as realistic and implementable in day to day practice?

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Author request: This article is based on original research carried out as part of a research dissertation undertaken at UCC. The findings presented in this paper represent only a small sample of the overall research findings. The author is interested in pursuing further opportunities to disseminate the findings. The full study can be made available on request by presentation or otherwise.

Abstract

Discourses surrounding values and ethics are central to the professional of social work. This paper focuses on the role of values and ethics in Irish social work practice. Drawing on findings from original research it explores the place of both traditional and emancipatory values as they are viewed by practitioners in the field. It also explores which values workers view as realistic and implementable in day to day practice. The methodology employed to achieve these aims consisted of a structured literature review coupled with a web-based attitudinal survey. The sampling process resulted in 128 responses, 111 of which were complete. Overall findings suggested a marked preference for traditional value types with many respondents indicating that the tasks associated with emancipatory values are best placed with other groups in Irish society.

Keywords: Social Work; Values; Ethics; Traditional; Emancipatory; Discourses; Genealogy.

Introduction

Social work has undergone much change over the course of its existence, emerging from charitable/ voluntary efforts in the late 18th and early 19th centuries to become both an academic discipline and a practical and applied profession requiring those who practice to hold a recognised third level qualification (Skehill, 1999; Thompson; 2009, Horner, 2009). Throughout this development values have held a constant presence.

When considering the development of the social work value-base most Irish social work practitioners will be keenly aware of Biestek (1961) who is widely credited with formally describing what have since become cemented in place as traditional social work values. They will also be aware that during the 1960s and 70s new sets of values characterised social work discourses as emancipatory values began to emerge (Banks, 1995; Thompson, 2009). Contemporary social workers operate within formal codes of ethics which should ideally function to define practice (see BASW, 1996; NASW, 1999 IASW, 2006 for precise examples). Broadly speaking, there is simply no denying the importance of values to social work and along with knowledge and skills, values form one of the three central pillars of the profession.

However, despite this importance, in reality social work values and ethics are abstract and contested concepts and therefore extremely difficult to adequately and satisfactorily define (Banks, 1995; Shardlow, 2002; Dominelli, 2002). The research presented in this paper aims to shed light on which values Irish social work practitioners identify as realistic and implementable in day to day practice. The theoretical foundation used to lend intellectual rigour to this paper draws on the work of the philosopher Michel Foucault (1977; 1984; 1987; 1988), particularly his notions of genealogy and discourses, and this shall be detailed in the first section of this paper. Following this, and in order to lend context to the findings, a brief examination of the genealogy of social work values and ethics, including how these discourses are imparted in educative settings, will be presented. This will followed by a description of the methodology used to complete the research. The findings will then be presented along with a brief discussion to conclude the paper. It is hoped that this paper will help lend insight into and generate debate about the place of social work values in contemporary Irish social work practice.

Foucault: Key Concepts

When seeking to understand the development of social work values along with contemporary codes of ethics a theoretical language that provides a basis for this understanding is essential. This is particularly true when examining what may be viewed as the competing discourses of traditional and emancipatory values. In this respect, this study has employed a form of discourse analysis throughout and in doing so has sought to enhance understanding through the persistent application of concepts developed by Foucault (1977; 1984; 1987; 1988). Further explanation of these concepts is given below:

Discourse(s): Discourses may be viewed as variable ways of specifying knowledge and truth and therefore contain and control considerable power (Powell & Khan, 2012). When a discourse becomes embedded and largely accepted it can be referred to as a discursive formation or a hegemonic discourse (Foucault, 1984; 1987; Fairclough, 2005). This research proposes that discourses are embedded within structures and

organisations and function to legitimise and justify the activities of said structures or organisations. So, in this case, the discourses of values and ethics are viewed as being embedded within the structure of organised social work, acting to legitimise the role and function of the profession. The accepted techniques of professional groupings effectively create 'true' discourses which constitute whole domains of knowledge and power (Foucault, 1977). This has the effect of destroying or delegitimizing competing discourses for example, the discourse of physics and science delegitimizes the discourse of the supernatural, the discourse of medical science delegitimizes the discourse of folk medicine or alternative therapies and the discourse of market economics delegitimizes the discourse of collective redistributive welfare policy and state sponsored services. A social work example may be how the discourse of managerialism delegitimizes the emancipatory discourse and ethos of the profession.

Genealogy (of discourses): Genealogy is very simply meant in the sense of tracing the historical developments that have lead to contemporary circumstances and discourses.

The ideas and concepts of Foucault have previously provided fertile ground for analysis and research relating to social work although this has not been extensive. Chambon (1999), writing in the US, has produced an edited book for those engaged in the process of thinking about or analysing social work from a Foucauldian perspective. Garrity (2010) successfully maps out the merits and benefits of using Foucault's discourse analysis as a tool to scrutinise the social work profession's values, policies and practices. Gilbert and Powell (2010) use the concepts of Foucault to explore the power relations that exist within the profession of social work. Powell and Khan (2012) acknowledge the work of Foucault as having provided 'conceptual gifts' suitable for the analysis of, and investigation into, social work. They argue that the use of Foucault's work can provide a deeper less assumptive understanding of power relations within the profession.

The Development of a Discourse: Values through to Professional Codes of Ethics.

When considering the development of the contemporary values and ethics discourse, Reamer (1980; 1983; 1994; 1998; 2006; 2014; 2015), writing in the United States, has published extensively in the area and provides a useful model for analysis. He has identified four distinct periods through which the genealogy of contemporary social work values and ethics is traceable. It is important to point out that these periods do not denote a linear progression and often overlap. They are detailed as follows:

1. The morality period;
2. The values period;
3. The ethics theory and decision making period;
4. The ethical standards and risk management period.

The 'morality' period refers to the late 20th century and posits that workers were more concerned with the morality of the client rather than what may have contributed to their need for intervention. This analysis is largely congruent with the Irish example where social work developed in the moral atmosphere of charitable intervention couched in the language of catholic social teaching (Curry, 1998; Cousins, 2003; Considine & Dukelow, 2009). Further highlighting the link between social work values and religious morality it is interesting to note that Biestek (1961), himself a Catholic priest, is credited with developing what has subsequently become identified as the traditional social work value-base in his seminal work The Case-Work Relationship. In this, Biestek (1961) developed seven principles of social work. Because of their on-going importance to social work they are listed as follows:

1. Individualisation;
2. Self-determination;
3. Purposeful expression of feelings;
4. Controlled emotional involvement;
5. Acceptance;
6. Confidentially and a...
7. Non-judgemental attitude.
8. The values espoused by Biestek (1961), while highly individual in nature, remain hugely relevant in social work today.

The period in which Biestek was writing arguably encapsulates what Reamer (1998) referred to as the 'values' period and was marked by a focus on developing specific social work values. Further notable contributions from the values period came from Levy (1972; 1973) who attempted to develop a typology of social work values and subsequently went on to help create and develop social work codes of ethics (Chase, 2015). Between this and Reamer's (1998) third period saw the emergence of what have come to be known as emancipatory values (Highman, 2006; Thompson, 2009). These differed extensively from traditional social work values in that their focus was far more political and much more focused on matters of social justice and structural inequalities (ibid, 2006; ibid, 2009). Much of the emancipatory movement in social work originated in the US and was perhaps reflective of the turbulence of that period there (Reamer, 1998). Academics and practitioners espousing emancipatory values were openly and directly critical of traditional casework approaches (Chase, 2015; Reamer, 1998). Notable entries from this time include Emmet (1962), Lucas (1963), Plant (1970) and Lewis (1972).

Reamer's (1998) third period is referred to as the 'ethics theory and decision making period' and is characterised by a renewed focus on applied professional ethics and can be viewed as being reflective of developments in the field of medical ethics. This period has led directly to the fourth period which is named as the 'maturation of ethical standards and risk management period' and which is

arguably most reflective of contemporary social work in Ireland today. It is the period of the social worker as the 'bureau professional' (Parry & Parry, 1979) who works within a hierarchical structure where ethics and values represent a code for practice, a guide for conduct and a template for decision making (Spano & Koenig, 2007; Chase; 2015; Banks, 2013; Reamer; 1998). While the discourse of values remains largely intact, located within these codes of ethics, it is arguable as to how reflective this discourse is of actual practice.

Delivering a Discourse: Values in Social Work Education.

When considering how the discourse of social work values develops for individual practitioners it is interesting to examine some of the literature as it relates to values in educative settings. Imparting a strong and robust discourse denoting social work as a value-led profession must almost certainly form part of any social work educative curriculum (Hugman, 2005; Mackay & Woodward, 2010). Hughman & Smith (1995) echo this sentiment and argue that the teaching and imparting of the profession's value-base is the single most important aspect of training new social workers. However, such a task is not without challenge. For example, Clifford & Burke (2009) argue that methods relating to the teaching of social work values remain under-developed while Allen & Friedman (2010) acknowledge the essentialness of imparting social work values to students but argue that a difficulty arises from the fact that the take up of these values is incredibly difficult to assess.

Compounding this difficulty, it is also possible to suggest that there are competing values discourses in social work education and that these are reflective of the conflicting discourses within the profession itself. Mackay & Woodward (2010), writing in Scotland, have recognised this. They highlight the influence of neoliberal market driven ideologies and managerialism in the formation of social work curricula which, they argue, is reflective of governmental influence on modern social work codes of ethics. They further argue that students, in their experience, consistently do not recognise the more structural components of the social work value-base. Furthermore, they suggest there is a preoccupation among students with individual approaches to values at the expense of structural analysis and critical reflection. In a follow-up piece, concerning the same themes, Mackay & Woodward (2012) conducted a small scale research project where 22 student social workers answered a qualitative questionnaire relating to values. The results showed that for students, values often remain abstract. Students were also found to have difficulty in articulating around the area of emancipatory values and many struggled to say how they would apply such values in practice.

Research Design

The study was conducted by way of an attitudinal survey using the web-based survey platform, Survey Monkey. Participants were provided with brief explanations of the intent and purpose of the study as well as clarification of the researcher's meaning of the specific topics under study. For the purpose of this research, traditional values were defined as those which are perceived as being more individual in nature whilst emancipatory values were defined as those that place a greater emphasis on structural inequalities. Aside from the section seeking participant profile information, the survey utilised forced choice attitudinal measurement devices such as the Likert scale throughout (de Vaus, 1999, Bryman, 2012). Estimated at between five and ten minutes, the survey was designed to be relatively quick to complete. The purpose of this was to help generate a higher rate of response. Participants were also given the opportunity to comment after each section in an optional comment box.

The Sampling Process

This study was conducted using a purposive sampling technique which is where a specific group or cohort are deemed to hold the answers to the questions being asked and so are deliberately and exclusively targeted (de Vaus, 1999, Bryman, 2012, Whitaker, 2012). The cohort in this instance was made up of practising social workers. A form of snowball sampling was also utilised as initial contact was made with gatekeepers—largely in the form of principal social workers—who were then encouraged to re-transmit the survey to other suitable participants (de Vaus, 1999; Bryman; 2012; Whitaker, 2012; Dawson, 2013). As this was an electronic survey all distribution and subsequent redistribution was carried out by way of email. An exhaustive and comprehensive campaign to enlist participants was undertaken through a number of avenues of enlistment. A breakdown of the resulting sample is detailed below:

Results of the sampling process:

Sampling resulted in 128 responses, 111 of which were complete. Of the 111 who answered 86 or 77.5% identified as female and 25 or 22.5% as male. Age range was highly varied with 2 respondents identifying as being under 25; 30 as being aged between 25 and 35; 29 as being between 35 and 45; 27 as being aged between 45 and 55 and 22 as being aged between 55 and 65. There was also a significant variance in respondent roles, with the majority (60%) of respondents coming from child protection backgrounds. This is given more detail in fig 1.1.

Fig 1.1 Respondent roles.

Answer Choices	Responses	
Child protection services	60.00%	66
Mental health services	4.55%	5
Probation services	1.82%	2
Disability services	1.82%	2
Medical social work	10.00%	11
Community based social work	5.45%	6
Fostering or adoption	10.91%	12
Other	5.45%	6
Total		110

Data Analysis

Very simply speaking, there are two basic types of statistics, descriptive and inferential. Descriptive statistics are those which summarise patterns in participant responses. Inferential statistics seek to identify if the patterns observed are generalisable to the whole of the population from which the sample was drawn. The data being presented here has been analysed using both techniques (de Vaus, 1999, Whitaker, 2012). The aim has been to present and describe findings in order to identify trends or patterns that may generate discussion.

Values and Ethics Discourses in Social Work: Key Findings

One of the key objectives of the research was to explore social work values and ethics discourses in professional practice. In order to first get a very general sense of the importance of values participants were first asked to respond to the statement that social work values represented an important feature of day to day practice. Of the 109 who answered an overwhelming majority either agreed (58) or strongly agreed (48) with this statement.

A Hierarchy of Values:

In order to then begin differentiating between different values-types—and their respective importance to practising social workers—participants were asked about the roles of traditional values and emancipatory values respectively. When asked if traditional values played an important role in practice a strong majority of respondents agreed that they did with 61 agreeing and 29 strongly agreeing.

When participants were asked the same question in relation to emancipatory values a marked difference was apparent. An overall majority (58) still agreed that emancipatory values are important in practice; however, it was it is a much smaller majority than that which was received in relation to the importance of traditional values. The question relating to emancipatory values also generated a much greater neutral response (45). Taken together, these findings lend credence to the notion of competing discourses within the overall discourse of social work values and ethics (Chase, 2015; Reamer, 1998). They are also, arguably, indicative of the ambiguity surrounding the espousal and articulation of emancipatory values (Mackay & Woodward, 2010; 2012).

In order to further understand the place of values in social work practice, participants were provided with a list of specific values, both traditional and emancipatory, and asked to identify the 3 values which they felt featured most in their day to day practice. Fig 1.2 details the results:

Answer Choices	Responses	
Acceptance	18.92%	21
Non-judgmental attitude	55.86%	62
Client self-determination	27.93%	31
Empathy	52.25%	58
Unconditional positive regard	17.12%	19
Equality	16.22%	18
Social justice	22.52%	25
Partnership	45.95%	51
Empowerment	45.05%	50
Total Respondents: 111		

Fig 1.2: The values which practitioners feel feature most in day to day practice.

A non-judgemental attitude was chosen 61 one times with empathy being chosen 58 and these represented the two most popular values of the choices on offer. Both represent values that can be characterised as both traditional and individual in nature (Thompson, 2009) with their formal origin traceable to the work of Biestek (1961). These were closely followed by the values of partnership and empowerment which, conversely, can be characterised as emancipatory (Thompson, 2009). However, while partnership and empowerment are describable as emancipatory or radical values, they are, arguably the more individual of this type. They can and have been associated with advocacy and empowerment approaches (Leadbetter, 2002) or approaches such as the strengths perspective (Saleeby, 1997) each of which have been criticised in part for being overly individualistic and ignoring the potential for wider structural problems in clients' lives (Payne, 1997; Gray, 2011). Moreover, it is noticeable that other important, and arguably extremely salient emancipatory values, namely social justice and equality, scored quite low, with equality representing the overall lowest scoring value despite social work's overt commitment to the realisation of same. Again, this is arguably reflective of competing value discourses and is suggestive of an apparent trend of ambiguity or apathy in relation to emancipatory values (Reamer, 1998; Mackay & Woodward, 2010; 2012; Chase, 2015). These findings are then further borne out and reiterated in other findings. For example, when exploring value-led tasks a majority of respondents (44) agreed that matters of social justice are best pursued by other groups in Irish society, with many others (36) preferring to remain neutral. This is despite the fact that an very strong majority of respondents (89) had previously identified social justice as a key practice value.

When it came to the general notion of addressing structural inequalities a marked ambiguity was apparent with a slight majority of respondents (44) agreeing that this was a realistic expectation in everyday practice, many others choosing to remain neutral (32) and a sizeable proportion of disagreeing altogether (35). Mirroring this, a majority of respondents (56) also agreed that there are other groups in Irish society who are better placed to address structural inequalities with 32 preferring to remain neutral and only an overall number of 19 disagreeing.

These findings demonstrate the concept of a hierarchy of values in day to day to social work practice. They also identify which values social workers feel are most realistic and implementable in day to day practice. They also, arguably, reveal an incongruity between many of social work's espoused values and the reality of practice on the ground. These findings also reveal something about how those working in the profession view their role. Despite social work espousing an overt commitment to pursuing social justice and addressing structural inequalities many of practitioners who took part in this study feel these tasks are best placed elsewhere. It can therefore be argued that social work values in Ireland belong firmly in the 'maturation of ethical standards and risk management period' (Reamer, 1998) of articulation.

Conclusion

The research findings presented here are important because they show, for the first time, which values feature most in Irish social work by quantifying which values practitioners view as realistic and implementable in day to day practice. The findings also go towards quantifying the feasibility and frequency of particular value positions by examining which value-oriented tasks—such as the pursuit of social justice and addressing structural inequalities—practitioners view as being best placed with other groups in Irish society. Arising from this undertaking it becomes possible to construct a hierarchy of values (see fig 1.3) in Irish social work practice which can then be generalised to the professional social work population as a whole.

Fig 1.3: A hierarchy of values.

This hierarchy of values places what are typically characterised as traditional social work values in a position of prominence. These are then closely followed by more emancipatory, yet still highly individual, values. The last group represents a mixture of value types and can arguably be interpreted as an ambiguous grouping.

Having established the concept of a hierarchy of values in Irish social work practice what remains unknown is why this is the case and why the hierarchy takes the form it does in respect to the prominence of certain values over others. This research was designed to quantify the frequency of phenomena—in this case values—thereby providing a picture of the place of values in Irish social work practice. It was designed to tell us what social workers think, but not why they think it. However, by drawing on previous research and literature and also on common experience, it remains possible to infer.

Firstly, an ambiguity around the articulation of emancipatory value types is something that has arose in previous studies. Mackay & Woodward (2010; 2012), mentioned here earlier, conducted research at the student level and have shown that student social workers struggle with the more structural components of the social work value-base. Furthermore, they suggest there is a preoccupation among students with individual approaches to values and a difficulty for students in articulating around the area of emancipatory values with many struggling to say how they would apply such values in practice. However, the fact remains that Mackay & Woodward's (2010; 2012) research was carried out within the student social worker population and although student social workers and social work practitioners share a common trajectory of experience they represent two very different cohorts along that trajectory. It may be possible to suggest that difficulties surrounding the articulation of emancipatory social work values begin during the educative process, but substantially more work would need to be carried out to in order to verify this assertion.

Secondly, when examining the emergence of a hierarchy of values, it is notable that an overall majority (66) of the survey participants—as representative of the majority of practising social workers—identified as working in child protection roles. Child protection social work represents an intensely procedural and tightly defined statutory role which is governed by standard operating procedures and richly detailed business plans (*see Tusla, 2016*). This may have a limiting effect on which values are realistic and implementable or even desirable and necessary in day to day practice. This assertion is borne out by some of the child protection workers who participated in this study and who chose to highlight their views through use of the optional comment box whilst completing the survey. For example one respondent noted that:

Because social work in Ireland is dominated by Child Protection, ideas of promoting social change and empowering and liberating people to enhance their wellbeing are becoming devalued.

Another respondent noted that:

Standard business processes have hindered true social work practice which is now based on ticking boxes rather than working with individual people and families.

And a further respondent noted that:

I feel that there is quite a clash between social work values and the demands of agency and agency policy and practice. This causes a lot of angst for social work practitioners who wish to uphold the integrity of social work values.

These and similar sentiments were echoed repeatedly by many of the participants who chose to comment, the vast majority of whom occupied child protection roles. Therefore, it is possible to suggest that the value hierarchy present in Irish social work practice is reflective of practitioner roles. However, the fact remains that the verification of such an assertion would require much more work of a qualitative nature in order to be borne out conclusively.

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Fabrication or Induction of Illness in Older Adults: A Rare Form of Maltreatment

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Abstract

Fabrication or Induction of Illness (FII) in older people (persons aged 65 years and above) by carers - such as a family member, companion, or staff member - is a unique type of abuse in which carers invent or induce illness in an older person under their care to gain attention or self-praise for helping them (Bennett, 2007) (Also known as Munchausen Syndrome by Proxy).

This collaborative community-based research study was undertaken by a University College Cork (UCC), Master of Social Science student (Esther) under the auspices of Community Academic Research links (CARL) and a community partner (Pauline) called Age: Wisdom and Hope (http://www.ucc.ie/en/scishop/rr/ click on 2015). The study was inspired by the practice experiences of professionals working with older adults who were looking to access research studies to inform and support their work with older adults at risk of harm.

The aims of the study were to undertake a comprehensive search for information on FII in older people, to analyse policy and practice in this area, and to locate research studies on FII in older adults. The authors found that FII is a type of abuse that could happen to older people who depend on others for care and support in a family, residential or non-residential facilities and abuse can happen in all of these care contexts. Extensive search was undertaken to locate literature regarding FII in older adults; however, only a few published case studies were located. The paper also found that Irish policy in this area needs to be updated and there is a need to increase public awareness in general and amongst professionals who work with older people.

Introduction

Although Fabrication or Induction of Illness (FII) in children has been well documented (Schreier, H. 2002), very little is known about FII in older people. Referring to older adults, Deimel IV et al. (2012, p. 294) showed that FII in older adults 'was under recognised and there was insufficient documentation to inform professionals that FII could take place with potentially devastating consequences.' In addition the article also highlighted a major lack of information on FII in older people, compared to children (Deime IV et al., 2012). This may make it difficult for professionals working with older people to work on FII cases using a sound evidence base which may contribute to difficulties with identifying older adults at risk of FII. Therefore, the purpose of this article is to contribute to the knowledge base on FII in older people.

This paper firstly, outlines in brief the origin of FII and what is known about it with regard to older people. Secondly, the paper highlights published case studies and lessons learnt from them. Finally, the paper concludes with policy framework by addressing some of the challenges related to the protection of older people from FII related abuse.

Origins of FII

Fabrication or Induction of Illness - also known as Munchausen Syndrome - was named after a German cavalry officer called Baron Munchausen born around 1720. The Baron used to entertain his friends with exaggerated stories from his military experiences. The term Munchausen Syndrome by Proxy was then used in 1951 by an English Physician Richard Asher to describe adults who fabricated illness in themselves (Frye and Feldman, 2012). Meadow coined the phrase Munchausen Syndrome by Proxy to describe children who were presented for medical examination by their parents with exaggerated and medically unverified illnesses, or illnesses that were induced by their carers (Meadow, 1982).

Postlewaite (2010) referring to FII in children noted that, the phrase 'fabrication or induction of illness' is now preferred as it puts focus on children rather than perpetrators. It concentrates on the harm caused to children and reflects on the wide range of behaviours being included in this form of abuse. It also guards against FII being understood as a discrete medical condition. Since then, hundreds of cases relating to FII regarding children have been published and less than 10 on older people (Burton et al. (2014).

In Most European countries people are living longer and there are increasingly ageing populations which could

mean that this FII type of maltreatment could become more prevalent. Timonen (2008, p.3) argues that 'Society in general and young adults in particular tend to find the studies related to ageing and older people in particular irrelevant, yet ageing affects everyone globally.' We believe there is a need to highlight what is known about FII in older people to inform professionals working with older people and hopefully society, so that potential victims could be protected.

What is known about FII in older people?

Fabrication or induction of illness in older people is a unique form of abuse in which a carer (family member, companion, staff) fabricates or induces illness in a person receiving their care and support with a view to gaining attention, or self-praise for the care giver role played (Bennett, 2007). An additional problem with FII is that it could also involve professionals playing a role unknowingly by carrying out unnecessary medical or non-medical procedures, assessments and tests in the name of treating the feigned illness. This could lead to unintentional harm and even death of an older person (Gilbert, 2014), hence the need for public and professional awareness to protect vulnerable older people in all settings of care.

The motivation of perpetrators are varied and complex, but can include: attention seeking for the carer through access to facilities and professionals or gaining praise for helping older people, assuming a sick role by proxy and being seen as a 'wonderful carer'. Perpetrators' psychological needs are met through the attention they get during medical evaluations or involvement with various professionals (Deimel et al, 2012). Signs and symptoms may include:

- An older person having unverified medical conditions / unexplainable, recurrent illnesses
- Interfacing with medical or non – medical processes involving older people
- Carer being over protective, over caring, over concerned, over feeding the older person
- Carer being aggressive towards professionals and resisting efforts to help
- Giving contradictory information
- Causing an older person to appear disabled
- Older persons sudden health improvement in the absence of their carer
- Older person being moved from one nursing home to another or one institution to another
- Fear of losing a carer

Research findings from literature review

Research findings indicated that FII could take place in any setting, a participant in our study, (http://www.ucc.ie/en/scishop/rr/), (click on 2015) noted that 'I think it [FII] can happen anywhere. I think a general hospital or a paediatric ward could show this as equally as a nursing home, geriatric ward. Perhaps we just need to educate ourselves better in what to look out for.' (Julie, Medical Social Worker)

Furthermore, a number of writers on FII, both in children and older people have not only highlighted the problem with the lack of information and expertise, but they have also linked this lack of information and expertise to diagnosis. For instance Lazenbatt (2013, p. 61) referring to children argued that:

Diagnosis of fabricated diseases can be especially difficult because the reported signs and symptoms are problematic to confirm (when they are being exaggerated or imagined) or may be inconsistent (when they are induced or fabricated).

The rigorous literature review undertaken by the authors for this study where nine databases were searched, found no formal research studies on FII in older people. We did find six published case studies of FII in older adults. Thus, the authors of this article co-developed a checklist based on qualitative interviews with professional participants with experience of FII in older adults in Ireland on what to look out for if professionals suspected FII in older people. The checklist alongside the thesis on Fabrication or Induction of Illness in older people can be accessed on http://www.ucc.ie/en/scishop/rr/ (click on 2015).

The European Report on Preventing Elder Maltreatment (World Health Organisation, 2011, p. 1) states that:

> The European region has a rapidly ageing population … elder maltreatment will grow as a public health and societal problem. Further, there is concern that the impact of economic downturn might exacerbate the risk of elder maltreatment as pressure increases on societal and family resources. Despite this, much of elder abuse remains under reported and ignored in the World Health Organisation (WHO) European region.

Furthermore, The World Population Ageing Report, 1950 - 2050 (United Nations, Department of Economic and Social Affairs, 2002) noted that the population of older people is growing at a very fast rate in all regions of the world. People are likely to survive to old age and once they reach old age they tend to live longer due to gains in life expectancy in old age which is relatively high. As the population of older people is increasing across the globe, it would seem necessary to ensure that as citizens enter old age that they are well informed and protected from all forms of maltreatment.

Miler (2012, p. 17) stated that:

> A person is vulnerable if their daily existence depends on other people. Additionally, although in certain

circumstances older people may still posse legal capacity, their physical capability for instance to cook, wash or clean may have diminished. Therefore the inevitable need for a carer and the possible fear of losing one would place an older person at risk of maltreatment.

Arising from the fact that some older people depend on others daily for care, support and supervision, their welfare should be a paramount societal concern of everyone. Even though FII could still be either underreported or under recognised, we believe professionals and the general public should be kept informed about it, through for instance articles, seminars and workshops, then and only then can society begin to talk about it. Even if the incidence rate is relatively low, it is important that we know more about it and seek to protect those who are subject to FII from carers. Studies could examine: its extent and prevalence; assessment criteria; motivations of perpetrators; implications for policy and legislation. These studies would then inform the legal framework, policy and practice and protect the potential victims (http://www.ucc.ie/en/scishop/rr/).

Learning from published case studies

A comprehensive search of nine databases between 2014 and 2015 using these search terms, Fabrication or Induction of Illness in an older person and Munchausen Syndrome by Proxy in an elderly resulting in over 10,000 hits, only identified six FII cases in older people published, of which five were accessible in English, one in French (which we did not access) and no formal studies globally which underscores the paucity of the knowledge base on FII in older people internationally.

Our key findings of the five accessible case studies were that disclosures of FII in children were more widely reported than disclosures of FII in older people. In all the incidences, the suspected perpetrator was a close family member, friend or professional. This made it difficult for professionals or family members to recognise that someone close and who seemed genuinely concerned could actually hurt the victim. It was also found that in four of these cases the perpetrator was a female. This was attributed to the care role most females still played in the care and support of older people. Furthermore, attention seeking from professionals and family members for self and victim and assuming the sick role was found to be the main motivating factors of FII in older people. In rare circumstances was financial gain a primary motivating factor. Apart from that, the case reports were mostly published by medical professionals although, FII could take place in any setting where care is provided. The fact that these cases were mostly published by professionals in the health sector created a misconception that FII could only take place in a medical setting (http://www.ucc.ie/en/scishop/rr/). Cabral (2014, p. 81) argues that,

> There has been a misconception that FII perpetrators are focussed on the medical profession who need to be alert to this behaviour. However, the perpetrator will feed information to professionals from a variety of settings including teachers, education welfare officers, social workers and not just health professionals.

We therefore believe that everyone working with older people or providing care, including older people themselves, should be aware of FII as a type of maltreatment. Greater awareness of FII may help to reduce incidences of physical and psychological harm, unnecessary hospitalisations, and even death of older people. On the other hand, although FII in older people by carers may take place, the authors of this article do not rule out the possibility of false accusations. There remains a scarcity of information on FII in older people, including the aspect of false accusations which could be considered for further research.

Policy and Legal framework on the protection of older people

Although elder abuse is generally recognised the world over, FII as a type of abuse does not seem to be included in any of the published documentation on elder abuse. The definition of elder abuse in the European Report on Preventing Elder Maltreatment (World Health Organisation, 2011, p. 1) is:

> A single or repeated act or lack of appropriate action within a relationship in which there is expectation of trust that causes harm or distress to older people. This includes forms of violence such as physical, mental emotional, neglect, sexual, economic and financial abuse.

Although, the aforementioned definition of elder abuse is broad, we still believe there is room for the explicit incorporation of the FII type of maltreatment. This would help in highlighting the FII type of maltreatment so that professionals, the general public and older persons themselves would begin to recognise it and provide resources to prevent it and protect potential victims (http://www.ucc.ie/en/scishop/rr/). In highlighting the issue of FII in the elderly and persons with disabilities, Burton et al. (2014) pointed out that:

> The incidence and prevalence of Munchausen Syndrome by Proxy in older adults is likely to increase in future because of medical technology that allowed greater survival of cognitively impaired populations, who were dependant on the care of others, henceforth older people and persons with disabilities will be especially at risk.

Furthermore, most policies and legislation in Ireland and globally are generic when it comes to the protection of older people, even though it would appear that it is at this stage in life, older people require more specific than generic policy and legal provisions (Phelan, 2005) . However, as Phelan has suggested, most documentation

on the protection of older people seems to indicate that society still has a long way to go in recognising and reporting FII in older people and generally on the rights of older people (http://www.ucc.ie/en/scishop/rr/).

During our research participants noted that they knew no legal or policy framework that specifically highlighted FII as a form of elder maltreatment. It was also noted that FII was not mentioned in any of the national policies that addressed the plight of older people such as the Safe Guarding Vulnerable Persons at Risk of Abuse, National Policy and Procedures (Health Service Executive, 2014). Julie and Joan (Medical Social Worker and Nurse) noted as follows respectively;

> "To my knowledge FII isn't specifically mentioned in policies we have in the sense of protecting somebody. We have various categories of elder abuse, it's not specifically listed."
>
> "There isn't in my experience any formal way of dealing with it because there isn't any formal way of diagnosing it."

Although there seem to be limited policies and legal frameworks to guide the prevention and protection of older adults against potential FII maltreatment, we believe that when people begin to recognise, report and talk about it, there will be more information on what to do and how to diagnose FII in older people. Increased awareness amongst society may in turn lead to the inclusion of FII in legal and policy documents and hence contribute to the protection of older people..

Meanwhile, the authors of this article recommend that where professionals suspect FII in an older adult, they bring their concerns before a multidisciplinary team as has been the case when dealing with FII in children. Smith and Arden (1989, p. 334) discussing FII in children from the 1980's argued that:

> Multidisciplinary teams can successfully offer 'tag therapy' to patients and families, where each professional hands on the therapeutic baton to the next colleague in a mixed medley where skills are offered in the individual professional's own particular style.

Conclusion

Fabrication or induction of illness in older people is rare, under reported and under recognised and difficult to diagnose. However, it is a form of maltreatment that could happen to older people especially those who depend on others for care and support. Amidst a major lack of information and awareness of FII, older people may potentially be at risk of experiencing this form of maltreatment and hence this article seeks to highlight the importance of people having an understanding of FII. In recognising FII, the authors believe that this article, the checklist together with the thesis on Fabrication or Induction of Illness in older people are important starting points http://www.ucc.ie/en/scishop/rr/ (click on 2015) in raising awareness on the possible existence of this unique type of abuse and ensuring the future protection, safeguarding and rights of older people.

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Restorative Justice Practice: Rejection or Reflection of Social Work Values?[2]

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Summary: The field of restorative practice has in recent years extended beyond its origins in the justice sphere into many areas of public discourse. This paper confines itself to the practices of restorative justice. Even within that narrower field, the approach encompasses a number of models delivered by a range of personnel from the public, private or voluntary sectors. Given these variables, there is a risk that restorative justice could be rendered an 'amorphous' concept, representing all things to all people. The author explores the congruence between restorative justice practice and social work values in the Probation Service.

Keywords: Restorative justice, social work, probation, reflectivity, reflexivity, anti-oppressive practice, social justice, mediation, facilitation, conferencing.

Introduction

In this paper the author aims:

- to explore challenges in developing a shared understanding of restorative justice and establishing a common meaning for related terms and concepts
- to examine the extent to which the social work values of reflective, anti-oppressive and anti-discriminatory practice, social justice and client narrative are embodied within the philosophy of restorative justice
- to examine the professional social work environment in the Probation Service, and its congruity with restorative justice practice.

Working definition of restorative justice

Defining the concept of restorative justice can pose challenges. For the purpose of this study the author has adopted this working definition:

> Restorative justice seeks to redefine crime, interpreting it not so much as breaking the law, or offending against the state, but as an injury or a wrong done to another person or persons. It encourages the victim and the offender to be directly involved in resolving any conflict through dialogue and negotiation. (Department of Justice, New Zealand; Cunneen, 2002)

The origins of restorative justice

The origins of restorative justice in this jurisdiction derive in large part from a New Zealand Maori tradition of conflict resolution. The Maori argued that a wrong committed hurts the entire community and that the involvement of the family, community representatives and the formal criminal justice system were key to the success of their restorative justice process. They recognised a retributive element of that process, as the wrongdoer would be expected to feel a sense of shame for their actions: a quasi-punishment in itself.

The New Zealand government passed landmark restorative justice legislation in 1989,[4] following which the first family group conferences were convened (O'Driscoll, 2007). Conflict resolution through family conferences culminated in the formulation of a plan intended to empower the offender and the family by identifying strengths and so to support the offender in taking responsibility for the offence, making reparation and avoiding further offending. This practice model values reflectivity, social justice, victim healing, client empowerment and narrative

The role of social work in victim–offender mediation in Canada is evident from its inception in Kitchener, Ontario, in 1974 (Umbreit, 1999). The John Howard Society of Alberta (1997) traces the origins to the recommendation of Mark Yantzi, a Probation Officer, who proposed to court that two offenders with whom he was working might benefit from a meeting with their victim. This intervention became the early template for victim–offender mediation work in Canada and acknowledged the importance of narrative and dialogue.

In the United States from the 1970s onwards, Howard Zehr, Eastern Mennonite University, pioneered the development of restorative justice (Zehr, 2003). His approach was concerned with: 'who is hurt?', 'what are their needs?', 'who is obliged to meet these needs?', 'what led to the harm taking place?', 'who has a stake in finding a solution?' and 'what process needs to take place to involve the stakeholders to address the causes of the hurt and to put matters right?'

Wachtel et al. (2010) date the introduction of restorative justice in North America to 1994, through victim–offender mediation. They contrast the US retributive justice system negatively with Zehr's focus on the restoration of the wellbeing of the victim, an approach that values social justice, narrative and reflectivity.

2 This paper is based on a review of literature from New Zealand, Europe and North America undertaken by the author as part of a Master's in Social Science (Social Work) degree.

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4 Children, Young Persons, and Their Families Act, 1989 (CYPF Act).

The philosophy and values of probation practice vary significantly. Practice in the Probation Service in Ireland is informed by the values, principles and ethical standards of social work.

The Probation Service has championed and supported the development of two restorative justice projects – the Tallaght Restorative Justice Services (RJS)[5] and Restorative Justice in the Community (RJC)[6] – since their establishment in 1999 and 2000 respectively. RJS and RJC provide offender reparation panels and victim–offender mediation as appropriate. Both projects receive referrals from District Courts of summary or minor offences and, in recent years, from higher courts for more serious offences.

McNulty (2005) documents the introduction of family conferencing in the Children Act, 2001[7] as an intervention directed by courts to address offending by young people. McNulty notes that, from a social work standpoint, the main thrust of family conferencing is the empowerment of victims' or offenders' families. The conference, he says, offers a forum for their narrative, reflective account and dialogue.

In 2006, the Probation Service made a submission on restorative justice to the Joint Committee on Justice, Equality, Defence and Women's Rights. Michael Donnellan, Director of the Probation Service, in his presentation to the committee said:

> We heard this morning that restorative principles in Ireland are at an early stage. We need to develop a model of restorative justice suitable to our District Court structure. We do not seem to be clear about that and we need to investigate and see how it can be embedded in our everyday work. We have a unique opportunity to do this and we in the Probation Service, with the help of the Department [of Justice and Law Reform], hope to clarify that in the next few months, taking on board expert international advice. (Houses of the Oireachtas Report on Restorative Justice, 2007: 36)

In reviewing the report of the National Commission on Restorative Justice (Department of Justice, Equality and Law Reform, 2009), O'Donovan (2011) argued *inter alia*, that four main stakeholders are involved in restorative justice – victims, offenders, the community and the state.

Obfuscation in terminology

Obfuscation is defined in Wikipedia as 'the obscuring of intended meaning in communication, making the message confusing, wilfully ambiguous, or harder to understand. It may be intentional or unintentional.' Seen more positively it could be referred to as 'constructive ambiguity'.

5 https://rjs.ie/

6 http://rjc.ie/

7 http://www.irishstatutebook.ie/eli/2001/act/24/enacted/en/index.html

Cuneen's (2000) definition of restorative justice from New Zealand is used here as a working definition. However, restorative justice is a difficult concept on which to achieve agreement. It is often used interchangeably with the broader term 'restorative practice'. According to Restorative Practices Ireland:

> Restorative practice is used in a wide range of settings including criminal justice agencies, educational settings, and community services, statutory and voluntary organizations. Restorative practice can be used anywhere along the continuum of supports from prevention and early intervention, right through to victim offender mediation for serious harm. (Restorative Practices Ireland, n.d.)

Comparing this definition of restorative practice with Cuneen's definition of restorative justice, the term 'restorative justice' may be more clearly understood as confined to criminal or civil justice matters, and 'restorative practice' used in the broader context of family support, educational services, etc. In reality and common parlance, however, the terms are not clearly differentiated.

In restorative justice the distinction between the roles of mediator and facilitator is often obfuscated in discussing victim–offender dialogue. Mediation usually implies an impasse likely to require managed negotiation or an imposed resolution. Facilitation is usually focused on achieving a 'win-win' situation through the use of personal narrative and dialogue. Again, they are often used interchangeably.

The United Nations *Handbook on Restorative Justice Programmes* (2006) tends to maintain the power differentials associated more often with mediation. While it promotes the role of non-governmental organisations (NGOs) in restorative justice practice, a top-down structure and the forging of links between NGOs and government agencies is advocated.

In the Czech Republic, the Probation and Mediation Service, a government organisation, employs Probation Officers, who are described as 'mediators'. However it could be argued that their role is more facilitative, reflecting social work values.

> Their task is to manage the negotiation process, to create conditions allowing understanding between the participants, the reaching of a solution, taking into account both parties' interests. The mediators neither assess the conflict, nor do they decide on the form of its solution. (Ourednickova et al., 1996)

Van Wormer (2003) asserts that social workers engaged in restorative practice with families should take the role of facilitator for the parties and not adjudicator. The focus is, in her view, on dialogue and narrative and not the guilt or innocence of the parties.

Mediation assumes an expert knowledge and, by implication, a shift in the balance of power, towards the

worker who has a gate-keeping role. This role assumes the ability to control resources and also the proceedings (Christopherson, 2009).

Shapland and colleagues (2011) evaluated three UK Home Office-supported restorative justice programmes: two offered mediation and one offered conferencing. Shapland et al. found that conferencing was conducive to opening up avenues for further discussion and for the parties to move on with their lives. This model appears to accord best with social work values and methods, in that facilitation of the participants was largely focused on their arriving at sustainable solutions.

O'Donovan's (2011) concept of 'community' as one of four stakeholders in restorative justice is difficult to define, as it may be located as either a geographic or a social entity. Within a restorative justice context, both victim and offender are stakeholders in their own right while also part of the separate entity of 'community'. In restorative justice context, it is most often assumed that the 'community' is those who are closest to the victim and/or the offender, and act in a support role. At other times, however, the community is seen to represent or even replace the victim. For example, if a victim does not wish to attend a conference, a member of the community may be invited to represent the victim's interests.

The United Nations *Handbook on Restorative Justice Programmes* (2006) includes the following example of restorative justice as practised by the Probation and Mediation Service in the Czech Republic.

> As part of the pre-sanction process, a plan is put before the Court involving an assessment of the personal strengths of the offender and how their risk factors might be addressed.

In Ireland these tasks were a central part of Probation Service work for many years before the relatively recent advent of restorative justice, and have been conducted consistent with the social work code of practice. Many elements of good practice in probation have been retrospectively acknowledged as restorative practices.

Restorative justice: All things to all people?

Restorative justice has been variously described as a 'philosophy', a 'movement' and a 'practice'. Daly and Immarigeon (1998: 21) argue that restorative justice has 'sprung from sites of activism, academia and justice'. Within the criminal justice systems of most countries it is relatively recent in its introduction and still at a developmental stage.

Dale and Hydle (2008) describe a plethora of restorative justice models in Norway, from a national mediation and reconciliation service, which deals with criminal and civil cases, to street mediation operated by the Norwegian Red Cross. They also discuss the child welfare service, which is active in approximately 70 municipalities and uses restorative practice including family conferencing.

Hydle (2011), a researcher at the University of Tromso, points out the difficulties encountered in attempting to define these separate entities and their fundamental differences: public and private organisations, civil and criminal law distinctions and the use of volunteers. The interchangeable use of the terms 'facilitator' and 'mediator' adds to the problem of defining meaning, describing structure and understanding processes.

In the Irish context McNulty (2005) identified the families of victim and offender as the key players in restorative justice family conferencing. As mentioned above, O'Donovan (2011) identified four distinct players in the restorative justice process: offender, victim, community and state.

Despite the difficulties in terminology, semantics and by varied, sometimes almost all-encompassing models of practice, restorative justice can be understood as a form of conflict resolution used to resolve disputes which exist between parties and which can be viewed through the lens of civil, criminal and political arenas.

Probation models as 'fluid entities'

Probation practice internationally varies significantly (Van Kalmthout 2009). In some jurisdictions probation agencies are staffed by social workers; in others a variety of professions with other qualifications and experience are employed. Links between Probation Services and Prison Services also vary. In some jurisdictions the services are combined and in others they are separate. The role of Probation Officers in civil or criminal courts is also varied (Van Kalmthout, 2009).

The use of social work skills by Probation Officers in restorative justice practice will be influenced by the paradigm and discourse favoured by the particular jurisdiction. Duffee and O'Leary (1986), cited in Whitehead and Braswell (2000), suggest that from a social policy stance, probation agencies may follow one of four models, determined by the level of emphasis placed on the offender, the community, or both. They discuss *restraint, rehabilitation, reform and reintegration*, the last of these being viewed as offering an emphasis on both the offender and the community, consistent with restorative justice practice.

Brown (n.d.) argues that the safety of staff and the increasing number of high-risk offenders subject to community sanctions may move Probation Officers away from casework towards increasing social control. Brown cites Sieh (1990) in concluding that the increase in offenders subject to community supervision has forced a change in the role of Probation Officers, leading to an emphasis on the management and control of offenders exemplifying a 'law enforcement' bias. This focus, by implication, upholds and maintains power differentials between offender and Probation Officer, impacting on the application of both social work values and restorative justice practices.

Whitehead and Braswell (2000) discuss the pathways leading to the redefining of the role of Probation Officers

in the US. They describe a move away from the Probation Officer as 'avuncular advisor', a role was largely that of a social worker working in a law enforcement context but acting as a mentor. They describe a move towards an almost 'Dirty Harry' role, as adjuncts of the police, engaged in the monitoring of electronically tagged individuals and testing clients' urine. The concept of enforcement and overt social control is now paramount and the authors suggest that probation represents one of the two 'correctional options' – the other being prison.

There seems to be very little impetus for such probation work to encompass restorative practice. Although Whitehead and Braswell (2000) support Probation Officers' focus on working to equip offenders with prosocial and problem-solving skills for reintegrative purposes, there is a tension between the idea of probation as purely law enforcement, and its more human restorative-led face. They argue that the US probation model should be refined to encompass 'what works' principles and evidence-based practice, incorporating elements of rehabilitation and restoration principles as well as law enforcement.

Wachtel et al. (2010) argue that the terminology employed in the US criminal justice system leans towards punitive-influenced language even when discussing restorative justice conferencing. Wachtel notes contrasts between current US criminal justice practice and what he terms 'real justice' or restorative justice. He points out that the two models are opposed. It may be ironic that probation's move towards a more correctional or punitive approach has coincided with the emergence of restorative justice practice.

Victim involvement

Sheena Norton (2007) describes how any restorative justice work in probation must always be mindful of the other parties and that the victim and the community that has been harmed should have equal importance with the offender. She says that the social work values of anti-oppressive/anti-discriminatory practice are evident in the 'voice' of the victim being clearly involved. However, Norton (2007) cites Spalek (2003) in noting that research has not established a link between the development of the offender's victim empathy and reduced reoffending.

Whether in the form of facilitation, mediation or reparation, restorative justice can provide an opportunity for the victim and the offender to meet, to arrive at a mutual resolution and for the victim to feel a sense of empowerment by getting answers to their questions. Asking a question of the offender can prove liberating for the victim, independently of any answer given.

Collaboration and the rebalancing of power should be evident in restorative justice as practised with victims, encompassing principles of reflective social work practice. The process is in principle voluntary for all concerned and although invited to participate as an important stakeholder in the restorative justice process, not all victims wish to engage in the process. It could be argued that the victim's perception of the harm suffered influences their willingness to participate.

Victim–offender dialogue: Narratives and scripts

McNulty (2005) cites Palazzoli Selvini *et al.* (1980), Cecchin (1987) and Tomm (1988), and concurs that the use of circular questioning can be helpful in working with a family involved in a restorative conference. This reflexive technique can be used to establish both commonality and difference in the narrative accounts. Circular questioning involves the facilitator undertaking:

investigation on the basis of feedback from the family in response to the information he solicits about relationships and therefore about differences and change. (Palazzoli Selvini et al., 1980: 8)

With circular questioning, it is possible to identify patterns of family functioning and possibly problematic norms. This may offer an opportunity for the family and offender to reflect, consider new options and uncover and utilise strengths. Circular questions can help separate or externalize the problem for the client and, as such, offer a safe space for re-authoring their social scripts.

It is important for change and healing that participants have an opportunity for dialogue and for the offender to acknowledge the view of the victim within the conference. The acknowledgement of both the offender and the victim in restorative justice programmes influenced by social work values has the potential to restore equilibrium. The offender is able to explore their offending behaviour and the victim is able to give an account of the harm experienced which can be empowering for both.

Offender: Identification of strengths

Hall (2012) recommends a strengths-based approach or collaborative working with Probation clients aimed at identifying and using their personal strengths. For this to be successful, an understanding of the interaction between collaboration, power and the choice of language is important and restorative justice work can facilitate this.

If there is a bias towards language and power to the detriment of collaboration, the intervention is likely to fail. Hall (2012) encourages client narrative to allow for free expression and uncover the client's perspective. This lends itself to client and worker being able to reframe situations, to drill down and discover a client's inner resources and resilience and to identify how these could be to achieve a positive solution.

Watson and West (2006) argue that a solution-focused method of working with clients adopts a middle position between the management or professional agenda and the empowerment of the client. As there is a focus on moving forward with a positive outlook, this can work well as it positions the client as the expert in their own life. A strengths-based approach in working with clients in a

restorative justice programme allows for rebalancing of power even within a structured and mandated setting.

Community models: The way forward?

The Probation Service Restorative Justice Strategy (Probation Service, 2013) discusses how the philosophy of restorative practice has underpinned the mandate of the Probation Service for many years and emphasises the importance of the broader community as a vital stakeholder. The strategy includes a number of actions including the expansion of community-based programmes and the inclusion of additional categories of offenders. It commits to the wide application of restorative practices in the work of the Probation Service.

The state, the court and the role of the Probation Service

Working as an agency of the Department of Justice and Equality, the Probation Service employs staff with social work qualifications to provide court-ordered assessment and supervision and to provide a through-care and aftercare service in prisons.

Social work ethics and values are visible in everyday practice with clients and in multidisciplinary settings. The Code of Ethics of the Irish Association of Social Workers (2006) acknowledges power imbalances and consequent tensions in the care and control functions of social work. These are particularly prominent in working with mandated or involuntary clients.

Trotter (2002) argues that particular critical skills used by workers with involuntary clients in mandated settings are directly related to positive outcomes. Trotter identifies these as role clarification between worker and client, the use of empathy and a collaborative problem-solving approach. These skills are consistent with the promotion of social justice and human rights when delivered to a high standard and meet the requirements of the Code of Ethics of the Irish Association of Social Workers.

Dalrymple and Burke (2003) illustrate a framework for anti-oppressive practice in the social work profession involving the interaction of knowledge, values and skills and requiring the ongoing use of reflective practice by practitioners. Schoen (1983) has argued that social work practice needs to be reflective in the context of the ‘uncertain and complex world of service users’. In this context of professional values and practice, Probation Officers apply ‘what works’ principles and evidence-based practices as envisaged by Whitehead and Braswell (2000) in their assessments of and interventions with offenders.

The final report of the National Commission on Restorative Justice (Department of Justice, Equality and Law Reform, 2009) advocated the existing criminal justice bodies as the preferred vehicle for implementation of restorative justice in Ireland. The report eschewed the creation of a separate agency while noting that this had been the preferred option in several other jurisdictions. It recommended that the Probation Service should be the lead agency in the development of restorative justice practice in the criminal justice system in Ireland.

Conclusion

The practice of restorative justice in a European context traces its origins to the New Zealand Maori model of conflict resolution, the value system of the US Mennonite religion and the practice of a Canadian Probation Officer. From these origins emerge key principles: the reframing of an offence as a wrong that hurts the entire community, the consideration of an offence as harm that can be viewed from multiple perspectives, and the potential benefits of victim–offender mediation.

The diverse origins perhaps best explain the diverse models of restorative justice involving public and private entities and that employ volunteer or professional staff or a mixture of the two. Language and semantics remain ill-defined or ignored in the development and delivery of restorative justice services. The interchangeable use of terms such as ‘mediation’ and ‘facilitation’ can obfuscate important power and status differentials and, together with the plethora of models available, may risk rendering restorative justice ‘all things to all people’.

The multiple models of restorative justice practised in Norway made it difficult to establish with certainty whether elements of social work values are implemented in the delivery of services. In the United Kingdom restorative justice programmes based on a facilitation rather than a mediation model seem a better ‘fit’ with social work values.

In Ireland the Probation Service has remained at the forefront of restorative justice development through its role in the criminal justice system and the wider ‘justice family’, its support for community-based restorative justice projects and its engagement in family conferencing. This role includes the provision of a framework for restorative justice, and the establishment of standards and criteria for training and service delivery.

The Probation Service’s involvement in restorative justice is congruent and consistent with social work values. Restorative language and practice is employed to explore the offender’s worldview and to develop the offender’s understanding of the victim perspective and the harm caused. The use of anti-oppressive/anti-discriminatory language in social work practice is central to its compatibility with restorative justice.

In my literature review on the congruity between restorative justice practices and social work values, findings were inconclusive. To a greater or lesser degree social work values can be consistent with the practice of restorative justice, depending on the model of restorative justice and practices employed.

In addition to the plethora of models of practice espousing a restorative justice ethos, the absence of a shared meaning and definition of terms and language

makes it difficult to draw firm conclusions about the fit between restorative justice practices and social work values generally. Compared with developments in other jurisdictions, restorative justice in Ireland has significant and substantial congruity with social work values.

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Social Work Training in Ireland: Is generic Professional training adequate to modern social work?

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Abstract:

This article questions if the quality control of professional social work and perhaps the sustainability of the profession is possible without the parallel evolution of the professional training and qualification structure. Specifically it raises questions about the generic nature of social work training in Ireland and the potential risks therein. It suggests that generic training does not stand up to the specialised demands of certain social work roles and that this raises professional and ethical questions and pressures. It also highlights that the current structure may compound the personal and professional burden that social work practitioners experience and that evolving the current training structure could be protective of practitioners as well as beneficial to service users. The aim of the article is to stimulate discussion about the value of proactively debating and developing the structure of professional social work training in Ireland.

Key words: Social Work Training, Generic Training, Specialist Training Skills, Ethics, Standards, Professional Training, Regulation, Career Progression

Introduction

CORU's 2016 strategy for the coming four years identifies that Ireland has experienced a cultural change over the last 25 years in how it views and trusts those in authority. It notes that people are now motivated to *'demand accountability from those who have been given power by society to carry out critical tasks for the benefit of all'* (CORU, 2016, p.10). However, rather than responding to demands for accountability, which often come retrospectively, this article is an attempt to think proactively and to begin to imagine how professional social work training might look in the future.

There has been a dramatic growth in the development of social work education worldwide (Barretta-Herman et al, 2016), and according to the IASSW 2010 census, 20 percent of required courses are taught by non-social work educators. This has the potential to bring helpful cross-pollination of ideas and also reflects that professional social work training is developing at a significant rate globally.

If we look globally we find definitions of social work that are exceedingly broad (IFSW, 2014). With definitions of social work that encompass innumerable permutations of the types of work that social workers can and should be doing, it is essential that we continuously review our approach to professional education (Sheehan, 2016; Taylor & Bogo, 2014, Yaffe, 2013). This article is intended to serve as an invitation to critically debate the current structure, and adequacy of social work training in Ireland. The article is not intended to be a critique of the quality of the tuition currently in place, or of the expertise that lecturers, tutors and practice teachers currently offer. Rather, the critique is clearly directed, specifically, towards the future structure of professional qualification and training as it relates to the demands of current day social work.

The evolution of demand

The profession has experienced extraordinary evolution over the last 40 years and in particular in the last 15 years. The early 1990's saw new legislation, increasing remits for social workers and an increasing demand for social workers in the labour market.

Such developments have unarguably created an increasingly complex and demanding work context for social work professionals. The professional questions that this situation raises are not new. Skehill (2003) has already reflected that "evidence on social work developments and practices between 1970 and 1991 suggests that the profession was fraught with dispute and confusion over whether social workers should be experts in child protection or generic practitioners over this time period" (p.149). Skehill also described and evidenced how one consequence of this has been that, 'social workers have taken on more of a role of case-manager than a therapeutic intervener (Thorpe, 1994; Farmer and Owen, 1995; Gibbons et al., 1995; Parton et al., 1997)" (pg144). This article suggests however that such confusion, dispute and consequent moulding of the profession has not been confined to the area of child protection social work. The specialism's of social

work are multiple and the need to consider the merit of differentiation between generic and specialist intervention and among specialist roles remains debated but actually unaddressed by the profession (Yaffe 2013; Healy & Meagher, 2007)) It is difficult to envisage how this can be addressed in practice until it is addressed in professional training.

At present regardless of whether a client needs an advocate, a counsellor, a source of information, a court report, a psychotherapeutic intervention, or an investigation into an allegation of child abuse, they will be directed to a generically trained social worker. This situation surely begs the question about the need for both generic and specialist social workers. However, as it stands, Ireland's current professional training structure is not accommodating the training needs created by increasingly complex and specialist interventions that some social workers are mandated to meet in their everyday practice. The 2008 NASW code of ethics makes specific ethical demands of those responsible for social work education, demands which hold a particular challenge in relation to practice placement training, "social workers who function as educators, field instructors for students or trainers should provide instruction only within their areas of knowledge and competence and should provide instruction based on the most current information and knowledge available in the profession" (section 3.02a). Whilst this appears to be stating the obvious, if considered more deeply it has ramifications for consideration of graduates competencies. If a student has had a mental health placement but not a child protection one are they to be considered competent in both? It is evident from current employment trends that employers do not think so. A 2016 job advertisement for a professionally qualified social worker in St. Patricks Hospital, Dublin, stipulated the need for mental health experience and stated that a practice placement in mental health would be considered. This is a clear example of an employer's view that particular training brings with it particular expertise.

Zufferey & Gibson (2013) identify that it is well documented that social work graduates feel unprepared for work with vulnerable children. Approaching the idea of generic training as not providing sufficient specialist skills; a study by Rhen & Kalman in 2016 explored student reflections on the challenges in their field work training placements. The study highlighted students' experience of their generic training as resulting in an overwhelming experience where, "having too much latitude in the interpretation of principles and guidelines (was) experienced as aggravating circumstances, whereas having knowledge of legislation and clear guidelines to follow was experienced as facilitating client interaction and as providing a sense of security with the professional role" (pg1). Given the wide ranging remit of social work, the range of legislation and guidelines relevant are vast and arguably too vast to learn comprehensively at a generic level.

Yaffe (2013, p525) states that it is reasonable to assume that poorly trained social workers might have the potential to be harmful to the eventual recipients of their services. While this article does not seek to argue that we currently have poorly trained social workers, it does argue that if we can observe that the range of legislation and interventions that social workers engage in has increased and developed in complexity then it is essential to wonder how generic training will continue to provide sufficient knowledge and skills to graduates in the future.

An Australian study which considered the need for specialist training in forensic social work found "social workers reported that their experience of post-qualifying education led to adaptations in the nature of their practice and the development of generic skills. This enabled them to incorporate an awareness of the effects of the justice system on mental health and to balance what are often opposing needs and considerations when working in this contested area" (Sheehan, 2016: pg.1). If the literature offers us evidence of both the gaps left by generic training (Rhen & Kalman, 2016, Walsh, 2010; Healy & Meagher, 2007; Luckock et al, 2007; Guskey, 2000; refs) and of the benefits of specialist training (Sheehan, 2016; Hatton – Bowers, 2015; Connolly, 2010; Mitchell, 2001) then this begs the questions as to why our core education and training structures are not formally evolving in the light of such knowledge?

Career progression

Currently, career progression in social work in Ireland is based around progression to levels of seniority and management roles within the context of employment rather than progression of clinical expertise within the context of training (Brennan 2009). Specialisation as distinct from career progression appears to be a matter of personal choice rather than specialist training. If a graduate is interested in child protection they will apply for work in that area, if they are interested in medical social work they will apply there. Over 20 years ago, and less than a year out of my own professional training, I was working in a specialised treatment programme for adolescent sexual offenders because I was interested in the area, not because I had especially specific specialist training in the area. In recent years I have observed recently qualified graduates with a year or two of social work practice in diametrically different roles, come to take up positions in specialised posts in mental health. This situation has required that those new recruits invest a lot of personal time up-skilling in their new specialist area. It is not unreasonable to extrapolate that this experience is replicated in other specialist social work posts. In fact it must be, as no specialist social work training exists to make it otherwise. However, this approach to specialist skill acquisition is clearly dependent on the personal commitment and motivation of individual social work staff and on the quality and sufficiency of the supervision available. Both of these factors may be highly influenced by external factors (Bogo & McKnight, 2005) and as such, are vulnerable to wide variations. The consequent ethics of this situation therefore becomes questionable.

An already overcrowded curriculum in social work training (Arnold et al, 2008) is no excuse for effectively leaving specialist expertise to chance. The merits of specialist social work training for specialist social work roles, where practitioners are given responsibility for life altering decisions for children and families, must now be addressed.

Professional Internal Role Division

If social work can be practiced in both generic and specialist ways then surely it necessitates the capacity to professionally train in both ways. Other professions have long recognised this need as evidenced by their training structures. Psychologists can practice only in the position of assistant psychologist subsequent to their primary degree, after which they must specialise to develop their expertise. Educational psychology, clinical psychology and counselling psychology all occupy differing specialist roles within the profession of psychology. Nursing too has both general training and specialised training for specific work contexts like paediatrics, or mental health etc. The models for such training structures are not however confined to other professions. Social work outside of Ireland, most notably in the U.S.A., recognises three distinct categories of social work practice which reflect the separation of generic and specialist practices. In the U.S. divisions are made between direct social work (generic), clinical social work (specialist) and macro social work (researchers and policy makers). These distinctions in practice also reflect distinctions in professional training and qualification. The American organisation for social work licensure offer a simple description of the distinction, "Both direct service and clinical social workers are at the front lines, working with needy individuals and families. However, clinical social workers have some expertise that direct service workers do not. They have a broader scope of duty" (Social work licensensure.org: 2016).

In my own career I consider I have practised 'direct social work' in a number of settings. For example in hospital social work I often worked with families and their local public health nurses, G.P's, and palliative care teams etc to ensure that families would have the support structure they required when discharged from hospital. I also worked with families in this context to ensure that they had understood their own or their child's treatment and to ensure they were able to engage with it. In other settings I advocated with charities and statutory services for adequate housing provision or family support services to ensure that basic needs were met. I did not however provide those supports myself. This does not mean that I did not have a therapeutic relationship with them, I did. On the other hand, different social work posts in my career have most definitely fallen into the other category of 'clinical social work'. Clinical social workers are less involved with directing and allocating service provision and are instead providing the requisite services themselves, for example counselling interventions. My experience of 'clinical social work' has been predominantly in my post as a social worker in Child and Adolescent Mental Health services. In this context I have had some influence over the provision of services but predominantly I have been tasked with providing direct interventions with children and their families where a presenting child or adolescent has been deemed to have a 'psychiatric' condition. The intervention needed by someone who identifies as gender fluid is not the same as someone who hears voices. The interventions certainly have generic elements, the social worker – client relationship remains key, the political and rights based issues connected with the intervention are key, but the specialised knowledge needed and available on both these issues is unarguably distinct from the generic elements of the work.

Specialist social work training

Specialist post qualification training for social workers almost unavoidably leads us away from schools of social work and into qualifications like play therapy, art psychotherapy, systemic psychotherapy, C.B.T. qualifications, Marte Meo qualifications and many others. All useful qualifications, but none are specific social work qualifications or require a social work qualification as an entry requirement and none of those are available in social work faculties at university level. There is an arguable exception in U.C.C.'s higher diploma in advanced field work practice and supervision. However this course is aimed at up-skilling social work practice teachers rather than practitioners. Whilst this is a very progressive educational move in social work education, it does not speak to the gap in specialist training in applied social work practice. Following professional qualification, any social worker wishing to stay clearly within the field of social work (i.e. engage in postgraduate training for which being a social worker is a requirement), appears in Ireland, to only have the option of a research degree. Whilst this may satisfy the researchers of the profession it does little to speak to the needs of practitioners.

Many social workers in specialist posts in Ireland hold additional non-social work training (Brennan, 2009). Masters degrees in fields like art psychotherapy, play therapy and family therapy which are trainings that take several years to complete are expensive and labour intensive. Despite this they are undertaken by Irish social workers to supplement their training and are in certain specialism sought by employers. In 2002 Family Therapy training was included as 'desirable' in the criteria for the social work post I continue to occupy in CAMHS. However despite resulting in an entirely new professional qualification, such training does not effect social work remuneration in any way. In this way social workers are arguably propping up the social work education system by going outside of it and studying at additional expense to meet the needs of specialist social work posts. If such training is being undertaken then surely this is evidence that social work educators and accreditors need to reflexively consider the evolving needs of the profession and of specialist professional training.

Current vulnerability

Despite a lack of a specialist professional development structure within Ireland's university social work schools, it is clearly possible to argue that social work in Ireland has nonetheless, developed along the generic/specialist distinctions evident in American social work. The lack of official structure has however greater consequences than social workers undertaking additional training outside social work schools. It creates a situation where social workers are vulnerable to lack of professional and public clarity about their role and therefore also to unrealistic and wildly varying expectations. It is of course possible to practice generic and specialist social work in the same post however this should not be understood to suggest that every generically qualified social worker has the skills to do so or has even appreciated that they might be expected to do so.

Expectations emanate from multiple and at times competing directions; service users, colleagues, the public, employers and the self. In child protection services for example, is the role of the social worker to make an assessment and refer on to other services?, or is it to make an assessment and provide a service? It is my professional experience of 20 years that the answer to this question depends on who you ask, how much pressure the person you are asking is under, and how much pressure their service is under. This is not a reasonable situation for service users, but it is also not a reasonable situation for social workers working in this context. Such a situation means that social workers face constantly shifting expectations on all sides. With no differentiation in professional training there is no professionally driven source of clarity about what is reasonable, feasible and safe to expect of social workers in differing contexts. This lack of clarity impacts service provision and the daily lives of social workers, clients, employers and services. This lack of clarity is arguably compounded, if not caused by, the lack of differentiation in professional social work training

Regulation

Simultaneously the current and relatively recent regulation of the social work profession and of other health professionals by CORU is also of relevance to this discussion. Regulation as a protective mechanism for the public is to be welcomed and has been well met by social work as a profession. However we would do well to attend to the anticipated regulation of the professions of counselling and psychotherapy by the same regulatory body. If the current criteria for counselling and psychotherapy accreditation are to be used as a guide, social work could, conceivably, soon find itself unable to assert that it is qualified to do either. Social work placements currently require that students have undertaken over 1000 hours of field work practice. These hours are undifferentiated insofar as they can comprise of hours supplied by advocacy work, report writing, court work, fostering assessments, group work and welfare work to name but a few. Thus there is no clarity as to the amount of direct counselling hours undertaken in training. Additionally the opportunity for such field work on placement varies greatly depending on the agency remit. It is also entirely possible that social workers who see their role as largely focused on the provision of 'direct social work' may not view themselves as providers of counselling and have questions about their role as practice teachers in this regard. It is also likely that in any competitive and regulated labour market counsellors and psychotherapists will assert the need for anyone claiming to offer the same skill set to be able to evidence this. The politically and socially informed nature of the counselling that social workers can bring to bear is a valuable resource to clients and services and it is worrying to think it might be vulnerable to erosion by new guidelines but equally valid to consider that it might need greater attention if it is a practice specialism for some social work practitioners.

Recommendations

This article makes a number of suggestions aimed at protecting the profession of social work from erosion, and from overload, via the creation of clearer professional boundaries. It suggests that for social work to remain competent to meet the demands of future practice and to remain ethically viable, generic training needs to be placed as a starting point among a range of specialist social work training (Zufferey & Gibson 2013). Despite the value of social work's diverse approach to its own epistemology, there is an arguable risk of diluting social work's long-term credibility as a profession if its professional education remains as it is. With differing academic degrees offering comparable professional training and with social work schools restricting post qualification training in social work to research, professional social work training is difficult for the lay person to understand yet we are answerable to the public and to a lay dominated regulatory structure.

For this reason, I suggest that the following recommendations be considered by the profession and their educators and regulators:

1. Reforming the structure of the system of qualification to ensure that consistency is created across the Universities in relation to whether a primary or masters level degree is required to qualify as a social worker. Given the current structure a generic undergraduate degree which qualifies a generic practitioner presents as the most obvious starting point. However, I consider that this approach only be considered if the intention is to then to provide specialised advanced social work training at a master's level.
2. Given social work's broad ranging remit, the profession would benefit from the development

of a generic and eclectic primary degree and the development of an appropriate range of post-graduate degrees in specialist areas.

3. A range of post-graduate education targeted specifically at qualified social workers should be developed to meet the needs of different specialist practitioners like child protection practitioners, mental health practitioners, etc

Conclusion

If a more streamlined and standardised education system is created this will in turn support the development of an advancing career structure centred around greater clinical expertise rather than on years in the job or the willingness to become a manager. The creation of the senior practitioner post was a useful development however consideration needs to be given to the criteria for obtaining such posts. Currently practitioners with higher levels of experience can access such posts, however a requirement for further training might lend weight to the importance of quality and not just quantity of practice as being the desirable criteria for such posts. Rather than being seen as a burden for practitioners, such requirements could be welcomed as a support to ensuring we have the skills we need to do the job at hand and that the complexity of quality social work is recognised.

Commenting on the Narey's report on social work education Laming (2015) said: "Society requires social workers to do a tough and demanding job that often entails conflict and uncertainty. Clearly it is in the best interests of us all, especially distressed and vulnerable children and adults, that social workers are properly trained for the task. Currently it sometimes seems they are being provided with what may be termed a general education rather than being equipped with the knowledge and practical skills to successfully undertake this challenging yet potentially satisfying work".

This article suggests that the demands of social work education in Ireland should be debated and developed proactively rather than reactively, acknowledging and reflecting that we are a profession who need not just to be accountable for the significant power vested in us by society, but also to wield that power with intellect, identifying and anticipating future needs and responding with due diligence. As Yaffe (2013) states, social work education, like any other social work practice, has an ethical duty to work towards evidence-based social work education, and it is my view that the evidence base is clearly suggesting that the demands of modern specialist social work are superseding the preparation offered by generic social work training.

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BOOK REVIEWS

Social Work in 42 Objects (and more) curated by Mark Doel (2017)

ISBN 978-1-903575-93-2

I was once told that one should never start a book review with a statement " a must read " but for this book's intended audience I am happy to break this rule.

This book asked 41 social workers and some with relationship to the profession to choose an object that; reflects, has impacted upon, or has related to their working experiences. They are then asked to provide a short narrative to accompany their objects. Their stories and objects are then curated into 13 different sections with photos of the authors and engaging illustrations.

The 42 objects span twenty-four countries across five continents and as such reflect the wonderful diversity of social work. This diversity spans several decades and as such gives an insight into practice through time.

The photo of a scrap of material from a foundation hospital in 1767 placed by the mother of a baby to the budget sheet from 1974/75 highlighting areas of spending, to a group of students in Galway displaying their lego aeroplane as representing the beginning of their training in social work gives a sense of the progression of our profession.

Each object brings with it a narrative and with 41 to dwell on the reader might be drawn towards the profound question. Can social work be defined? On being invited to review this book I undertook briefly to look at previous reviews and was drawn towards a statement made by a Canadian social worker. "All Social Work is primarily concerned with health and wellbeing". Not that this book attempts to answer the question of defining social work but merely poses it.

In my reflections about such a quest I was drawn towards the box of artefacts used by Thomas Clarkson in his campaign journey to abolish slavery in the late 18th century. I wondered what story each artefact would tell, from the coins to the spices and what small part they would play in Clarkson's relationships with others to achieving his mission. In this regard, I thought maybe it is the journey that defines our definition rather than the definition itself.

Objects in Museums can tell powerful stories and evoke differing emotions. For those of us that have visited Museums that display artifacts presenting the darker side of humanity, the power and emotional impact of an object will be familiar. When I asked several people to read a brief extract from the book I was struck by the different degrees of emotions expressed. All wanted to tell a story about their object, and once given the space to do so, often divulged the emotional impact that was linked to their piece.

One person on random flicking through the book came across the hammer text and illustration. His reflections upon this was of the times and places where he was fearful in his statutory role as a social worker.

Another person not related to the profession but a full time carer, came upon The Beveridge Report (arguing for Universal Social Services) and commented "what a long way we have come but still a longer way to go ".

On viewing the photo of the letter opener, another worker was reminded of a leaving card a client had given her. The client was later charged with theft of the card, which resulted in his admission to rehabilitation, rather than facing a prison sentence. She like many of us with unfinished stories often wondered what had happened to him.

Reflecting upon this book I was mindful of never seeing a monument to a social worker or indeed the social work profession. We have our conferences, our meetings and gatherings which in a small way present our profession to the public. This is often received with mixed views about the role of the social worker from implementing statutory legislation, to working with the most vulnerable in society. These stories, artifacts and illustrations go some way to demonstrating the struggle, persistence, courage and ingenuity that many of us have gifted to those we work with. This book is also a gift to us from other social workers willing to share their stories and even the proceeds will go to a children's charity in India.

I have no doubt that this book will cause new social workers and those that have been gifted with the endurance of sustaining life within the profession to reflect upon their own objects. They might even have an eagerness to write it down. There are 41 objects with these stories. The space provided for Story Number 42 is yours.

John Hannon

IASW Member

"Bringing up Happy Confident Children. A practical Guide to nurturing resilience, self-esteem and emotional well-being" by John Sharry

I approached this book as a long-standing fan of Solution-focussed and Strengths-based perspectives in social work. I had enjoyed Sharry's earlier book "Becoming a Solution Detective". I also approached this as a parent of 3 children at different stages-hoping to gain some tips along the way.

The book is in two parts-the first a series of 7 chapters-each one a principle. Drawing on his columns in the Irish Times Part Two contains questions from real parents and answers addressing issues regarding confidence and self-esteem, friendships, school problems, and helping young people overcome stress, anxiety and depression. For the purposes of this book review I will focus on the 7 principles.

The book is an easy read, especially if like me you enjoy lists! It is peppered with examples from both practice and from the author as a parent.

Principle 1 Build Children's Character and Self-Esteem

This chapter advocates focussing on teaching universal values and encouraging your children's character strengths by:

- Encouraging them for effort and hard work towards a long term result
- Praising them for kindness, bravery, patience
- Getting them involved in projects that bring out the best in them

Principle 2 Love your children uniquely

Sharry says the most important contributor to a person's happiness and well-being is the quality of their family relationships.

He has a concept of the "emotional bank account" into which parents need to make positive deposits. These might be enjoyable time spent with a child, making a connection, enjoying an activity together etc. A withdrawal is any negative experience such as not listening to a child, a criticism etc. He recommends 5 deposits to counteract each one withdrawal. Positive deposits might include:

- Chatting on the way home from school
- Shared project e.g. decorating a room
- Following a football team

He has a nice concept of loving your children uniquely rather than equally.

Principle 3 Discover your children's strengths and talents

"Everybody is a genius, But if you judge a fish by its ability to climb a tree, it will live its whole life believing that it is stupid." Albert Einstein.

Sharry lists the 8 types of intelligence:

- Linguistic
- Visual/spatial
- Logical
- Bodily-kinaesthetic-hand-to-eye co-ordination
- Musical
- Interpersonal
- Intrapersonal-good self-awareness and understanding feelings
- Naturalistic-natural world

While he emphasises the need to help your child discover their strengths and talents he says weaknesses shouldn't be ignored-but advises putting struggles in context e.g. if a child has a particular difficulty then not allowing the child to be defined by their area of weakness.

Principle 4 Encourage your Children's Potential

- "nine-tenths of education is encouragement" Anatole France
- Switching criticism to encouragement

e.g. Instead of saying: "Why are you always so late starting your homework?" switch to "Oh you've got your books out, that's a great start".

To become an encouraging parent:

- Acknowledge feeling
- Focus on what went well
- State a positive goal
- Express positive belief in your children
- Appreciate your child's strength

Principle 5 Teach skill mastery and responsibility

Parents will love this, Sharry essentially encourages parents to give away the chores! However he does encourage matching tasks to ages.

Principle 6 Help your children contribute socially

Sharry says that "Sometimes simply helping this child make a contribution in their local community can be the start of them finding themselves".

He uses the example of An Gaisce (Presidents Awards) done in Transition Year in a lot of Irish schools as a good example of this where young people are required to complete an activity from each of the following:

- community involvement
- Personal skill
- Physical recreation
- Adventure journey

Principle 7. Develop your children's resilience

In true Solution-focussed style, Sharry uses scaling questions with an 11 item Developmental Assets Checklist (On a scale of 1 to 5, where 1 is strongly disagree and 5 is strongly agree) e.g.

- Parental connection "your parents love and support you"
- Peer role models "most of your friends are responsible"

In conclusion- I found this book to be practical, Common sense, Evidence-based, Solution-focussed/strengths based, useful for parents-starting with myself! It is certainly more of a resource for parents themselves, but I believe it could be useful for professionals working with parents also.

See also www.solutiontalk.ie

Sheila Mc Crory
Head Medical Social Worker Our Lady's Children's Hospital, Crumlin.

Social Work in a Diverse Society (2016) Edited by Charlotte Williams and Mekeda Graham

What caught my attention from the first page was the statement that this is a book about practice. The editors state it is about what is going on in the field and what we can learn from it. Additionally they write they are interested in developing theories that emerge from practice rather than the other way around. They call this embedded transformatory practice.

I personally felt a need within my own social work practice with ethnic minorities to hear about more than theory. Theories regarding diversity have indeed importantly informed my practice but I have felt unsure at times, in that, yes, I was using the frameworks provided by anti-oppressive theory and cultural competence but was I actually applying them in the most useful ways to assist service users? I felt somewhat confident I was thinking about diversity in the right way but not that I was always doing the right things. So I was excited to learn what other social workers were doing.

I found some validation early on which was a bit of a relief! The editors write that despite a significant body of theory there remains an identifiable gap between professional aspirations and the reality of making a difference on the ground. They add that anti-oppressive practice and cultural competence theories abound yet practitioners struggle to give a clear account of how they implement them. In order to begin to bridge this gap they decided an examination of practice wisdom was needed and this is what they set out to do in this book.

I believe they have successfully achieved their aims. For starters, the book brings together an academic and a practitioner to co- author each chapter which keeps the themes rooted in practice and also informed by the academic context. Each chapter then examines different practice themes and methods in various settings with people of minority ethnic backgrounds.

Early on the authors provide a framework for embedded transformatory practice with ethnic minority service users. The framework positions the voice of the minority service user as the starting point and highlights the relational aspects of encounters between service users and providers. It guides us to ask what are the narratives of race at work and how do they frame our understanding of the issue a hand. The framework also prompts us to ask where we are positioned in relation to opinions about ethnic difference. It proposes trust, dialogue and consultation as essential. Finally it encourages our micro level work to include skills of anti-oppressive practice, paying attention to power and power relationships and the ways in which social needs are constructed and communicated.

Chapter 2 uses the context of Northern Ireland as a society that has experienced colonisation, violent conflict and sectarianism to show how 'critical' cultural competence offers opportunities for transformative practice. Anti-oppressive ethical principles for social work practice are then proposed in Chapter 3.

Chapters 4 -13 delve into examples of practice on the ground which I found the most interesting section of the book. Stand out chapters include chapter 4 which explores a strengths based perspective in working with black families in the UK when there are child protection concerns. It contained a useful analysis applying cultural competence and reflective practice through a strengths perspective.

Chapter 5 resonated because it revealed the words and opinions of a group of young Muslin people living in Scotland. It reminded me how their words are not commonly heard or prioritised in dominant debates about their religion and culture and how social work can have a role in redressing this balance. Chapter 6 explores supporting service users with limited English language proficiency and the use of interpreters within this. I found

the case study to be very relevant to my role and the factors involved in using interpretative services

The multidisciplinary setting of mental health is researched in Chapter 9. The research identified the conflict inherent in discourses about diversity in multidisciplinary workplaces; at the individual level often an anti-oppressive discourse, at team level one of cultural competence and at organisational level a managerialism focus on resources, targets, monitoring and individual rights.

Service users' words were to the fore again in chapter 10 where the care experiences of Gypsy, Traveller and Roma children were explored. Transracial placements were researched through the views and experiences of Gypsy, Traveller and Roma individuals who were placed in transracial foster families as children. I personally found the words and in turn practice advice of these adults insightful and profound.

This publication didn't disappoint in that it did exactly what it said on the tin. It provided a rich and varied look at social workers making a difference on the ground in their work with people of diverse background. I would highly recommend it.

Edel O' Hara
Social Worker Enable Ireland Cork

Effective Group Leadership – Gerard Fitzpatrick Published by Orpen Press, 2016

First and foremost this book is a really engaging read containing a mix of theoretical material, case studies and personal experience. Gerard Fitzpatrick has an authentic voice and is not afraid to talk of his mistakes or occasional feelings of panic or failure. That in itself is helpful and reassuring for any potential or actual group leader, coming as it does from an obviously experienced and wise voice.

Written from a psychotherapeutic perspective Fitzpatrick first addresses the empowerment of marginalised people through group work and the qualities needed to facilitate groups that enable that empowerment. His work draws on major influences in the field such as Rogers, Yalom and Winnicott.

Following close behind he considers the importance of a facilitator being always involved in their own development and learning; questioning their own motivation and actions. His openness about his own perceived failings is instructive, resonant and reassuring – *"I sometimes find myself drawn to responding to challenges in a defensive manner. I perceive threat, react, then lacerate myself for not being sufficiently contained. As human beings we tend to jump to conclusions and once a conclusion is reached, we can be very resistant to changing it, indeed, feeling quite self-righteous acting out of it (Kahnemann 2012: Gaffney, 2011)" (p.66)* This paragraph precedes one of the many interesting insights in the book; as a facilitator you need to be 'good enough'. Indeed just as with Winnicott's 'good enough parenting' theory the 'perfect' facilitator is not the one that most enables growth in group participants.

He then addresses issues of group dynamics from the 'birth' of a group to its ending. This includes sections on making contracts, the development of group cohesion and good 'timing' in raising topics. Conflict in groups has a whole chapter to itself and Fitzpatrick discusses aggression, the quest for power and boundary issues in this section. He also presents some helpful material on dealing with conflict in groups. This material draws quite heavily on Transactional Analysis theory and suggests that '*working life is generally easier if we can maintain ourselves in the adult state …) (p.121)* Having said this he also points out times when being in the child or parent state can be helpful and he also discusses the possibility of conflict being useful and beneficial in the context of the group.

There is a chapter on 'Working to Needs' which considers the complexities of meeting a groups needs and also, importantly, satisfying funders and other stakeholders. He has some interesting thoughts on feedback and evaluation and how this might best be sought.

Finally, there is a presentation of case material which comes complete with Fitzpatrick's narrative and thoughts on various topics thrown up by the case material. This feels almost like an addendum but is nevertheless a fascinating read, some of it being a reinforcement of earlier material but also introducing new thoughts and ideas. In this section he particularly focuses on working with groups of unemployed people. But there is also an interesting and valuable discussion of participants' evaluation of their experience in a women's empowerment group. This charts the efficacy of the group and the development of the individuals within it.

There are two themes that run throughout this book. One is on utilising groups to enable people to empower themselves and the other is the requirement for the facilitator to be human, sometimes mistaken, never all-knowing but always on a journey of self-development.

One of the many strengths of this book is Fitzpatrick's ability to speak of his own journey without either arrogance or self-deprecation. I suspect this is where the greatest learning will lie for many readers.

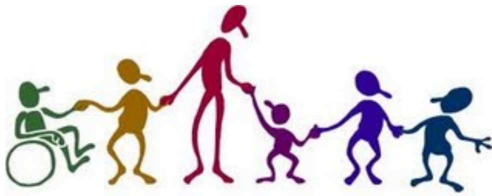
Effective Group Leadership isn't exactly a beginner's guide to how to run a group although it might well appeal to anyone who has an interest in group processes - or indeed is a group participant which we all are in one way or another. But it is rich in experience, theoretical understanding and humanity. For anyone involved in facilitating groups it is a book to keep close by.

Gerard Fitzpatrick is the Director of *Fusion Training and Development*, an Irish based company offering training programmes to both companies and individuals. He is a psychotherapist and also qualified and experienced in group facilitation. 'Effective Group Leadership' is his first book.

Rohana Reading
Social Worker

POSTER PRESENTATIONS

The following seven pages (54-60) feature Poster Presentations from the IASW National Conference 2017



Working with child relatives of adults with acquired brain injury : a resource for an interdisciplinary rehabilitation team

Phil Butler & Anne O'Loughlin, Social Work Dept

"I don't like the way my dad forgets things now" (12 year old boy")

Why include child relatives?

- Improves outcomes for rehabilitation (Daisley et al 2005). ***"Family coping appears to have a positive impact on the rehabilitation progress of the ABI survivor"*** (Moreno-Lopez et al, 'A grounded theory investigation of life experience and the role of social support for adolescent offspring after parental brain injury' Brain Injury 2011, Vol 25, No. 12, 1221-1233)
- Leads to more meaningful and practical rehabilitation life goals
- Reduces the emotional and behavioural difficulties for children
- Facilitates family adjustment & wellbeing

Aims and Objectives:

The project was designed to:

- Strengthen the family centered approach to rehabilitation
- Support staff to be more inclusive of child relatives in their interventions
- Provide ideas and suggestions on working with children
- Provide information on child development and how this impacts on their understanding of brain injury
- Provide resources for further information and onward referral

"I worry that I'm not doing enough to mind my mum " (9 year old girl)

Pilot Phase: Pack is currently being trialed with one ABI team and will be reviewed following feedback

Content:

- Literature review/rationale
- Effects of ABI on Child relatives
- Impact of ABI on parenting
- Helping children cope – tips sheet
- Common questions asked by children and teens about ABI
- Resources for child relatives
- Handouts for parents
- Child support agencies

"I didn't know how to explain it to my friends" (8 year old boy)

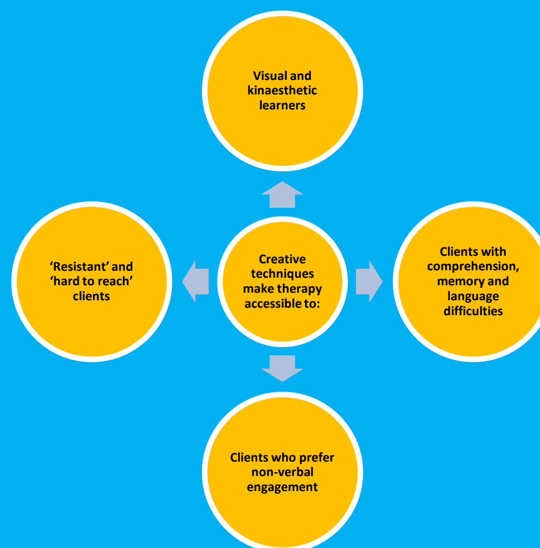
Creative Techniques in Contemporary Family Therapy: All Fun and Games?

Background

Creative techniques such as Satir's ***family sculpting*** and Minuchin's ***enactments*** have been a central feature in family therapy since its origins in the 1960's (Wiener and Pels-Roulier, 2005). This qualitative study explored their place and role in contemporary family therapy and revealed that while they have **multiple proven benefits**, they are underutilised. This case study used semi-structured interviews to gather the views of eight family therapists.

Findings

The findings revealed that: therapists do **not feel confident** in using creative techniques primarily due to **lack of focus** on them in **training** programmes; **organisational backing and good supervision** is important in supporting therapists with developing a creative practice; creative techniques can be grounded in both **positivist and constructivist paradigms** and are therefore **suited to contemporary family therapy practice**; creative techniques are **tools to develop good therapeutic relationships** which are a key factor in influencing the **outcome of therapy** (Flaskas, 2003); **creative techniques by pass cognitive and verbal defences**, they are **experiential** and elicit **multi-sensorial responses** which **accelerate the therapeutic process**; creative techniques can be applied to **a wide range of presenting problems** and **situational issues** such as addiction, anxiety, bereavement, depression, eating disorders, selective mutism and relationship difficulties; there are multiple other benefits to creative techniques that are illustrated in the graph below.



The findings also revealed that therapists can engage their **'use of self'** to develop a creative practice: therapists should **integrate** creative techniques into their **own individual style** of working rather than trying to imitate 'experts'; therapists should **prepare their therapy space** so that creative techniques can be drawn upon **spontaneously** in session; novice family therapists can **develop a creative practice** by **practicing** one model of family therapy in an orthodox fashion, once **confident** in the model therapists can **experiment with creative techniques**; therapists can engage with **music and the arts** to draw **inspiration** for creative practice .

Conclusions

- Family therapists who are skilled in creative techniques have a **wider therapeutic repertoire** which enables them to deliver efficient, **high quality therapeutic services** to clients with **diverse needs.**
- Creative techniques accelerate therapy thus providing **cost saving** opportunities for organisations.

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Pathways and Outcomes

A Study of 335 referrals (540 children and young people) to the FWC Service in Dublin, Kildare and Wicklow

O'Brien, V. and Ahonen, H. (2015) http://www.tusla.ie/uploads/content/Pathways_and_Outcomes.pdf

Family Welfare Conferencing

FWC is known internationally as Family Group Conferencing.

It is a process that implements the principles of partnership, participation and empowerment by **fully involving family groups in decision-making and planning for children and their care.**

Aims of the study

❖ To provide, through a file audit, a profile of 335 (540 children) cases referred to the FWC Service 2011-2013.

❖ To capture outcomes arising in cases

❖ To use the findings to help in planning future FWC Service provision.

"The families are united in wanting to face the problems together – good for the children, everyone got to share their opinions and offer help."

(family member)

Methodology and limitations

File audit + evaluation data collected previously.

Capturing data in respect of goals, concerns, categorisation of cases and change requires a *level of interpretation*.

It was *not possible to de-aggregate* the file data per individual child.

Lack of stakeholders' views, other than limited evaluation data collected as part of the individual FWCs.

Outcomes explicated only for those cases that got to a review stage (*73 cases*).

Process Outcomes:

Attendance at FWCs – average 11.8 family / 9 professionals

Family Plans – 95.5% of FWCs

Agreements/actions in family plans – 19.06

Commitments made by family / by professionals and follow up

"This process was a wonderful support to the child, parents and extended family. This process has been a great lead in showing how complex difficult situations can have positive outcomes when sensitive thinking and creative planning is part of the process. The conference atmosphere was supportive and helpful tone and allowed a relaxing atmosphere to tackle difficult issues."

(advocate)

"I find it helpful that there is a specialised service to support families to empower themselves to formulate their own plan. This takes the focus off professionals telling the family the best plan and encourages them to take responsibility for the plans in place"

(referrer)

Outcomes Relating to Children:

❖ 90.7% of cases had an improvement in concerns (overall in 54.8% of cases + somewhat improved in 35.6% cases)

❖ 35.6% of cases with no concerns

❖ In 70.6 % of cases the goal was achieved in full + partially in 14.7% of cases (fully in 80.5% of child protection cases and 84.6% of alternative care cases)

❖ Movement of children in relation to placements

❖ Reduction of children in care

❖ Cases where care was avoided

"We are all now fully informed and aware of the problems and how they impact on the child. We will ensure the child is looked after."

(family member)

Outcomes Measured

Process outcomes

a. FWC meeting
- Family and professional attendance
- Number of family plans and commitments made

b. Review
- Follow-through on commitments
- Whether goals set were achieved

Outcomes relating to children/young people
- Changes in concerns identified by the referrer;
- Changes in children's placements;
- Legal procedures avoided;
- Changes in legal care status of children.

Family Welfare Conference Service

Bringing children, families and professionals together

Family Welfare Conference Service, P.O. Box 12639, Dublin 8
Tel: 01-4150552 Fax: 01-4150556
E-mail: fwc@hse.ie

"Mastering wellness"
LGBT People's Well-being through Interest Sharing

Nerilee Ceatha
ceathan@tcd.ie

Aims

➔ An alternative perspective to the consensus of increased LGBT mental health risk[1] is forwarded

➔ The lack of research on LGBT well-being through interest sharing is puzzling in light of research with general populations on social well-being through community involvement[2].

➔ This qualitative research is aligned with emergent research trends problematising the dominant 'at risk' representation[3].

➔ Qualitative methods in exploratory studies are considered particularly effective in researching areas that are under-researched or subject to misconceptions[4].

Findings

➔ **Mastering wellness** emerged as a theme from the data where participants spoke of:

- ✓ developing an **awareness** of well-being and actively promoting positive mental health through shared interests
- ✓ the **breadth of well-being** with interest sharing as developing and maintaining positive mental health.
- ✓ **promoting self-esteem** through involvement in shared interests
- ✓ **creating balance** where interest-sharing with like-minded peers provides a resource for everyday

Discussion

➔ The sense of vitality that emerges suggests that LGBT people are active agents in mastering wellness on their own terms.

➔ In contrast with the general population[5], participants' presentation as confident and comfortable discussing mental health and well-being.

➔ It is generally understood that anyone may have times of mental ill-health and equally have times of well-being.

➔ This suggests that participants simultaneously challenge the stigmatising representation of LGBT-identities and mental health as binary constructs of normal/abnormal[6].

It's only been in the past few years I've really felt good - felt of sound mind. When I realised I was gay, when I started getting into [interest], learned a lot and met new people.

The benefits are enormous - I am a much nicer person, a much happier person…[it] ticks all those boxes… keeps me healthy, gives me time to reflect - that's the private meditation and processing part.

Method and Methodology

➔ Ten in-depth interviews were conducted with 11 people:

- ✓ lesbian (5), gay (4), bisexual (1) or transgender (1)
- ✓ aged 22 – 56 years
- ✓ 7 in relationships including civil partnerships (4) with 2 married (1 heterosexual marriage)
- ✓ 3 have children
- ✓ 9 are from Ireland, 1 from Europe and 1 from North America
- ✓ 10 completed 3rd level education

➔ Diversity was sought to ensure the breadth of sporting, creative, and social interests, in and outside LGBT groups.

➔ Interviews were transcribed and coded using thematic analysis.

➔ Ethics approval was granted from TCD Research Ethical Approval Committee

Key Messages

➔ The openness and ease of LGBT participants in discussing mental health has important policy and practice implications:

- ➢ recognise and affirm LGBT agency in mastering wellness
- ➢ recognise the cultural and social capital embedded within LGBT networks
- ➢ recognize the breadth of LGBT diversity by problematising the dominant 'at risk' representation and destigmatising mental health with LGBT communities
- ➢ 'learn *with'* LGBT communities[7] through practice that explores the benefits of interest sharing with like-minded peers.

Sunday…I call my "mental health day" - the day set aside for clearing my head. I tend to go out with the group…I deeply need that counterbalance.

That's fantastic, that's one of the best validation experiences - that makes me feel so awesome about [interest]…and so excited.

Acknowledgements:

- thanks to my thesis supervisor, Dr. Paula Mayock., TCD
- thanks to the 11 participants and the LGBT communities

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OBITUARIES

ELEANOR ANNA HOLMES
22 AUGUST 1923 – 7 MARCH 2016

(Head Medical Social Worker, Rotunda Hospital, Dublin, 1954 – 1987)

Eleanor Holmes, who died aged 92 in March 2016, was one of a generation who pioneered modern social work practices in Ireland. She grew up in Monasterevan, Co. Kildare, where her father Samuel E. Holmes ran an engineering works. Her mother came from Fivemiletown, Co. Tyrone. Eleanor was always very conscious of her part-Northern roots and always kept in touch with them. Her mother did not have good health during Eleanor's childhood and died when Eleanor was aged 18, and her brother and only sibling was aged 12.

After boarding at Methodist College Belfast, Eleanor spent some years at home in Monasterevan housekeeping for family members. A radiographer friend from Monasterevan encouraged her to become an almoner, and she went to Trinity College Dublin where in 1946 she obtained a diploma in Social Studies. She then continued with her professional training at the Institute of Almoners in London, the only option available in these islands at the time.

In 1954, after working for brief periods in Edinburgh and Belfast where she encountered many health-related social problems, Eleanor was appointed Head Almoner (later Head Medical Social Worker[1], in the Rotunda Hospital, Dublin, a position she held until her retirement in 1987. In her early years at the Rotunda Eleanor was very much to the fore in arguing the focus of the almoner should be the social care of patients, a priority that did not fit well with the bureaucratic requirements which continued to be imposed on almoners even after the 1953 Health Act. This stance did not meet with approval at first from the hospital boards, but Eleanor, along with a small number of colleagues, held firm and gradually the role of the Medical Social Worker evolved.

The main issues facing her department were severe poverty, especially in the tenements in the inner city, caused frequently by unemployment, frequent and numerous pregnancies and severe overcrowding with very limited sanitation. With more permissive attitudes developing around 1970 and with many single girls now keeping their babies, the issues facing the medical social work department expanded to take in more on marriage breakdown, non-accidental injuries to babies, family planning, more pregnancies outside marriage, a new approach to bereavement, drug abuse and the emergence of HIV/AIDS. Counselling assumed a greater role than in the earlier years. In all of these areas Eleanor kept well abreast of the times, adapting to and initiating change when she saw that change was needed. She was involved in lobbying for change in response to various needs, for example for a dietician and a consultant psychiatrist in the hospital, and for a Home Help Service in wider society. By the time she retired in 1987 there were four Medical Social Workers in a purpose-built department which she had designed to give more space and efficiency, and above all more privacy, to patients.

Eleanor was highly regarded in her profession. She was not afraid to challenge some of the more established practices of her time, for example she encouraged parents who had stillborn babies, or whose babies died shortly after birth, to see their babies and if possible to have a photograph of them. This was not always looked on favourably by some medical staff, as it was seen to be upsetting the patients. Her forthright personality sometimes caused tensions, but the interest of the patient was always a priority in her decisions. Eleanor was a feisty lady. She was always supportive of her staff, and had a sense of justice and liberal values which underpinned her outlook in her approach to individual cases.

Eleanor's chapter in the annual Rotunda Clinical Report caused her a good deal of anxiety every year, as, along with the various statistics and analyses of the work of her department, she always sought to give a vivid picture of changes in wider society that affected the patients. That the result was always worthwhile was evident when staff from other hospitals sometimes commented that her section of the report was the most interesting.

1 (The role of almoners, which in Britain had changed from assessment more to social care during the 1940s, changed in Ireland with the 1953 Health Act in Ireland, which came into force in 1954 – the year Eleanor joined the Rotunda. The Act was a pivotal point in the development of the social care aspect of the profession. The name Almoner subsequently changed to Medical Social Worker in 1964 to reflect this).

Her very comprehensive thirty-three page contribution on 'Medical Social Work at the Rotunda' in Masters, Midwives and Ladies-in-Waiting, the Rotunda Hospital, 1745-1995, the book produced to commemorate the 250th anniversary of the Rotunda, bears out her interest in the development of the Medical Social Work profession, from its early beginnings in 1895 in London to the appointment of the first almoner in Ireland to the Adelaide Hospital in 1921 (the Rotunda being the second in 1936) and up to her retirement in 1987. That she saw a humorous side to her job is illustrated in further more personal reminiscences included in The Alternative History of the Rotunda (1995).

For thirteen years Eleanor combined her full-time job in the Rotunda with domestic responsibilities in Monasterevan, by commuting daily. Then in 1977 she settled in Sandymount. After her retirement in 1987 she maintained her very strong interest in the Rotunda as an active member of the hospital Board of Governors between 1987 and 1997. She loved animals, especially dogs. She remained very active up to her mid-eighties - driving, swimming, and as a vestry member of St. Stephen's Church, Dublin, among other activities.

Due to declining health Eleanor moved to Brabazon House, Sandymount in 2011. She was well cared for and very happy there, still able to keep in touch with her large number of friends and colleagues from her profession. She was buried in the Holmes family grave in St. John's Church, Monasterevan on 10 March 2016. She is survived by her sister-in-law Christina Holmes and nephews Edgar and Ben Holmes.

Margaret Horner (formerly Margaret Burns, Medical Social Worker at the Rotunda Hospital, 1972-1985)

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Eamonn McCarthy
Principal Social Worker

TRAGIC LOSS OF AN OUTSTANDING PROFESSIONAL AND A TRUE FRIEND.

On the morning of Feb 16 this year, Social Workers and colleagues in the HSE and Child and Family Agency in Kerry were distressed and shocked to hear of the sudden and tragic passing of our friend and colleague Eamonn McCarthy Principal Social Worker.

Eamonn originally from Coolock in Dublin had moved to Kerry as Social Work Team Leader in Child Protection in Oct 1999. Eamonn a proud Dub had met his match in his beloved wife Bríd Prendiville a proud Kerry woman, and took to life in Kerry with gusto. Eamonn was appointed Principal Social Worker in Child Protection in 1991 and over the next 10 yrs was an innovative and committed PSW leading the development and progress of the Social Work team in Kerry.

Eamonn was a brilliant academic and receiving first place in Ireland in various exams was a norm. His first choice of career was as an Actuary, but as Eamonn used to say, he had no interest in making rich people richer, at heart he said he was a socialist, so he changed to Social Work where he could have a meaningful input in helping people to improve their lives. Eamonn studied in TCD in the mid eighties and was a Trinity Scholar, enjoying on occasion the pomp and privilege this bestowed.

On qualifying Eamonn worked in Area 8 in the old EHB, based in Finglas and in the Children in Care Team. Eamonn was known as a diligent and thorough professional, as well as being part of the rich social scene in the team at the time.

As PSW in Kerry Eamonn shaped the team at a time of many new entrants to the profession. Eamonn engendered a vibrant team spirit which still prevails, and as well as developing high professional standards, he led by example in ensuring the commitment to the children and families we worked with, was uppermost.

Whatever the task was, it was seen through and there was no going home until everything had been done to ensure the safety and protection of children. This legacy I am pleased to say lives on in the Social Work team. Eamonn was intensely proud of the response he got from his staff.

Social workers speak of Eamonn as very approachable, thoughtful, full of sound advice, they speak of him being always available, being mindful of staff, giving everyone the time they needed. They also recall Eamonn as being very meticulous in detail with files always in order.

Eamonn skills with computers was legendary and he personally set up the computerised data base that still serves the Dept to date.

Eamonn also enjoyed the social side of life and though usually the designated driver he was the last to leave the party signing his heart out into the small wee hours.

Outside of work Eamonn was a loving husband and proud father of three boys Kevin, David, and Mikey. Basketball was Eamonn's game and as well as playing a mean game himself he coached underage players and took great pride as his own boys developed into fine players winning provincial and national honours.

We were aware for a number of years that Eamonn was struggling with mental health issues, taking time out on occasion, and in 2011 moving from Child Protection to Elderly Services and Primary Care.

Notwithstanding same Eamonn maintained contact with all the Social Work teams, and enjoying the social outings with all his colleagues. Eamonn's colleagues maintained contact and were highly supportive during these years and were aware of Eamonn's plans to return to fulltime work in 2017.

The shock and sadness of Eamonn's loss will be felt for a long time to come, it has helped us to rededicate ourselves to the profession he loved and to look out for and be supportive of each other in difficult times.

To his beloved Bríd and sons Kevin, David and Mikey, his loss is immense and we offer them our heartfelt sympathy and our ongoing help and support.

O.M. Suaimhneas agus Síocháin duit a Fíorchara

The IASW Journal Guidelines (Updated September 2016)

These IASW Journal guidelines were updated as a means to offer additional guidance for the Author(s), assist those in reviewing the articles (reviewers/Editor) and enhance the quality of articles published. Part one includes the additional guidance.

The IASW Journal Committee requests Authors to follow the guidance below.

Please include the following: Part One

1. **Submission Process**

All articles should be submitted by Email for the attention of the Journal Editor. **Email: office@iasw.ie**

2. **The Article Title Page**

The title page should include the paper title, be concise and informative. Titles are often used in information-retrieval systems so avoid abbreviations

3. **Author Details**

Name of author(s), qualifications, author job title, brief relevant experience and email address

4. **Abstract (Summary) and Key-Words**

The page following the title page should carry an abstract followed by a **list of three to ten key-words**. The abstract, up to 150 words should include; a short outline of the article, the main purposes, findings and conclusions of the article or study while emphasising what is new or important.

5. **Introduction**

Include a short introduction, introducing the reader to the topic, your motivation for writing the article, a brief review of the existing knowledge related to the topic and a summary of your conclusions

6. **Conclusion**

Include a short conclusion summarising your thoughts and the importance of the article's findings.

7. **Acknowledgement**

Please acknowledge anyone who has contributed to the process of completing the article

8. **Text**

- The article should be typed, double-spaced and in 12-point Times New Roman font.

• Pages should be numbered but do **not** use any other automated features.

• Numbers one to ten should be written as words in the text, unless used as a unit of measurement; all numbers should be written in digits in tables and figures.

• All numbers which start sentences should be written in words, not digits.

• Bold type-face should be used for headings of sections and sub-sections within the paper.

• Writing should be clear, simple and direct.

• Short sentences are preferred.

9. **Tables**
Please submit tables as editable text and not as images. Number any tables consecutively in accordance with their appearance in the text and place any table notes below the table body.

10. **Word length**
Articles should be **2,000/4,000 words** in length

11. Include **agreement not to publish the complete article in any other Journal** (exception HSE Lenus, Open Access health repository with an agreement of six months delay: IASW will forward each published Journal to Lenus the HSE health repository for delayed publication)

Part Two: Publications House Style:

Harvard Referencing System

Citing references in the text
Writers' surnames only, with year of publication and page number, are given in brackets after the reference.

Example

1. **Reference from book**

Quotes of 3 lines or less are included in the normal flow of text and are given single quotation marks.

And as one writer suggests 'all living systems have boundaries which mark them off from their environment'. (Preston –Shoot and Agass, 1990:45)

If longer than 3 lines, then the quote is indented and no quotation marks are used.
If you are quoting some information about systems thinking and you want to use more than the 3 lines of the above example it will look like this

> The metaphor of open and closed systems can fruitfully be applied to many aspects of human functioning, as well as to theories and belief-systems. It can be used as a sort of shorthand to evaluate the condition of any human system, from individual to an entire social or national group. For example, an individual who is open to other people, to new experiences and to new ideas and who interacts productively with the environment. (Preston-Shoot and Agass, 1990:47)

And the rest of the paragraph reads like this back to normal format.

2. **Reference from article:**
'The coming together of such and impressive and yet diverse array of organisations for the specific purpose was in itself an historic landmark' (Lorenz, 1997:11)

3. **References from edited book:**
'The claim was that social workers had too much power to intervene in family life without being either useful or effective'. (Howe, 1996:83)

4. **Bibliography**
List all references in alphabetical order.

The format for listing **books** is as follows:

Author's surname, first name or initials, year of publication, title of book in italics, publisher's name and place of publication.

Where there are several references for one author, list them in chronological order by year of publications. If there are several publications in one year distinguish them by using a, b, c after the year.

a. **For chapter in book**:

Author/s surname, initials/first name, year of publication, title of article in single quotes, the name of the editor of the book in which it appears in italics, publishers name and place of publication.

b. **Article**:

Author's surname, initials/first name, year of publication, title of chapter in quote marks, title of journal in italics, and volume number and page numbers for complete article.

c. **Bibliography** would appear as follows:

Howe, D. (1999). 'Surface and depth in social-work practice.' In Parton, N(Ed), *Social Theory, Social Change and Social Work*, Routledge, London.

Lorenz, W. (1997). 'ECSPRESS – The Thematic Network for the Social Professions' in *Irish Social Worker,* Spring, Vol. 15 No 1, (11-12).

Preston-Shoot, M and Agass, D. (1990). *Making Sense of Social Work, Psychodynamics', Systems and Practice*. Macmillan, London.

It is acceptable to use the term, et al in the text only where there are 3 or more authors. So if Clarke, Loughran, Smith and Walsh were the authors it could be references in the text as (Clarke et al., 1997, 99) but full details must appear in the bibliography.

Please do not use footnotes or terms such as [op cit, ibid.]

Additional points

5. **Citation in text**
   Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full at the end of the abstract. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text.

6. **Web references**
   The full URL should be given and the date when the reference was last accessed. Any further information, if known (Digital Object Identifier (DOI), author names, dates, reference to a source publication, etc.), should also be given. Web references can be included in the reference list.

NOTES

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Ireland has 363,000 people providing care to a loved one without pay.

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They care for a loved one for on average of 45 hours per week.

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(Sources; CSO 2016, NUI Galway 2015)

The Social Work profession is best placed to take the lead in developing more support services for Family Carers.

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