IASW
Irish Association of Social Workers
Cumann na hÉireann um Oibrithe Sóisialta

The Irish Social Worker

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IASW AGM & National Social Work Conference 2020

Annual General Meeting

Date: Thursday 7th May @ 4:30pm

Venue: The Ashling Hotel, Parkgate Street, Dublin 8

Further information can be found on www.iasw.ie

National Conference

Title: Keeping Adults Safe: Rights, Risks and Vulnerability

Date: Friday 8th May – Full Day Conference

Venue: The Ashling Hotel, Parkgate Street, Dublin 8

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EDITORIAL

Dear Members

Welcome to this special edition of the Irish Social Worker, open access, practice and research journal featuring a presentation and articles from the IASW National Conference and the All Ireland Social Work Research Conference 2019.

We are delighted to be able to reproduce a presentation entitled ‘Object Poverty’ delivered by staff and participants of the Saol Project as part of the IASW Conference in May 2019. Sixteen objects associated with poverty served as a rally call for different issues. Their creativity enhanced with art and music helped to increase awareness of what it is like to be caught up in a cycle of homelessness, poverty and addiction in modern day contemporary society.

We have twelve peer reviewed articles, one of which derived from the IASW National Conference and nine of which derived from the All Ireland Social Work Research Conference held in Dublin on 14th June 2019. Through the work of the Practitioner Research Special Interest Group, the IASW became aware of the high volume of research being carried out by social workers around the country. As a means of recognising this valuable work, a small committee organised this conference to showcase the high calibre of research carried out each year. The organising committee made up of volunteers; Niamh Flanagan (Maynooth University), Sarah Donnelly (UCD), Kerry Cuskelly (IASW) and Eavan Brady (Trinity College) received an over-whelming response to the ‘call for abstracts’ and reviewed over sixty applications. On behalf of IASW, I would like to take this opportunity to thank the organising committee, our consortium partners and their representatives: Eavan Brady – TCD, Declan Coogan - NUI Galway,Sarah Donnelly – UCD, Carolyn Ewart - BASW-NI, Niamh Flanagan - Maynooth University, Carmel Halton – UCC, Campbell Killick - University of Ulster, Aine McGuirk – IASW, Lorna Montgomery - Queens University Belfast and Leigh-Ann Sweeney - Sligo IT. The consortium funded the event making it free to all practitioners and students.

I would like to acknowledge the work of the judges, room managers and volunteer teams comprising of students from the consortium universities, Danielle Mc Goldrick (Office Manager IASW) and Sylvia Ryan (Continuous Professional Development Officer), John Brennan (IASW) for capturing the event with his brilliant photos and to the staff at Carmelite Community Centre, Aungier Street, Dublin who hosted the event.

A special word of thanks to Senator Colette Kelleher who provided us with an inspirational and engaging keynote address.

In this edition of the Irish Social Worker, readers will find research, analysis and lessons from practice. Themes include: relationships, poverty, child welfare, fostering and adoption, mental health, community education, service user involvement and co-production, acquired brain injury, youth participation and integrated care.

I would like to thank all of the authors for contributing their knowledge and expertise to this special edition journal. In particular, I would like to thank members of the journal committee Frank Browne, Colletta Dalikeni, Brid Joy and Steven Peet and our panel of expert external peer reviewers who provided invaluable guidance, advice and support to the committee in reviewing each of the articles.

We look forward to our next edition and encourage and invite writers in social work, policy, practice and research to submit papers and research findings for publication in the Irish Social Worker. All articles published in the Irish Social Worker are peer reviewed by a blind panel of practitioners and academics with support and guidance offered by the editorial committee.

All articles published in the Irish Social Worker journal will be available after six months, (with the authors permission) to Lenus the Health Service Executive (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 enjoy this special edition of the Irish Social Worker.

Majella Hickey A/Editor

PUTTING RELATIONSHIPS FIRST IN SOCIAL WORK

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Keywords

Relationship; service user perspectives; youth justice; mentoring; volunteers; co-working; participatory research; co-production.

Introduction

‘Relationship’ is not just at the heart of social work (Trevithick, 2003), it is the heart of social work. The essence of social work has always been the importance of this collaborative partnership with service users. As the profession has evolved relationships have grown in scope and complexity. This article, arising from the 2019 Irish Association of Social Work (IASW) conference, Putting Relationships First, considers relationships in an expansive way addressing key relationships in practice. Adopting an ecological approach to social work practice relationships, the article considers the importance of collaborative relationships between social worker and service user across the range of practice activities. It considers factors that may contribute to, support or detract from relationship building in social work practice; it explores the opportunities for collaborative relationships in therapeutic practice; it looks at relationships in co-working opportunities that can emerge through engagement with volunteers in service support and delivery; and moving beyond therapeutic practice, it considers service users as partners in social work education, research and service delivery

Starting from the core of social work practice, as partners in the development of relationships, service users have important information about what works. The experiences of service users from a community project of what works for them and reflections on what building meaningful relationships really mean, provide significant insight into what social workers need to address in the relationship building process. The social worker/service user relationship is followed by a discussion of relationships in co-working with volunteers in service support and delivery in a youth justice support services as a case study.

While relationships in social work predominantly focus on engagement with service users in term of interventions, the conference took a more expansive approach to relationships. It moved from building relationships in an interpersonal context to working collaboratively in social work education and service delivery, building a case for a more strategic collaborative relationship between social workers and service users in research.

Collaborative relationships

From the early days of the profession, working with people through building collaborative relationships was central to the mission and core values of social work. Recognising and respecting the importance of building relationships are prerequisites to our commitment to promoting social justice and anti-oppressive practice. 'The essence of social work has always been the importance of this collaborative partnership with service users' (Loughran 2019:8).

> Parent: *"It's all about relationships. We are talking about dealing with people with problems, with painful stuff. You have to know someone, trust them. They must be reliable and be there for you if you are going to be able to talk about the things you don't want to. The things that scare you" (Munro, 2010:3).*

As the profession has developed 'relationships' have grown in scope and complexity. For example, the emergence of social work in child protection may present challenges as commitment to partnership with parents does not always sit easily with mandatory responsibilities. Building collaborative, trusting relationships is inevitably complicated when social workers and service users may not agree on the possible outcome. Challenges for putting relationships first go beyond the obvious difficulties associated with preferred outcomes. Evidence clearly demonstrates that spending time building collaborative, supportive and trusting relationships with service users is not only consistent with the social work value base, but it is also an effective way to work toward change (Forrester *et al*, 2019; Knei-Paz, 2009; Munro, 2010, 2011).

> *Helping children and families involves working with them and therefore the quality of the relationship between the child and family and professionals directly impacts on the effectiveness of help given (Munro, 2011:23).*

However, as Loughran (2019:8) highlights, across different aspects of social work practice we must 'look at the increasing pressure of caseloads and waiting lists… with the potential difficulty of trying to do too much in too short a time'. This can be further hampered by limited resources (Lindahl & Bruhn, 2018).

Supporting Relationship building in Social Work Education

As already mentioned, there is some concern that the importance of spending time building collaborative relationships may be hampered by heavy caseloads and limited resources (Loughran 2019:9; Cooper 2011). Social work students are taught the skills of relationship engagement through employment of core counselling and communication skills. These include the fundamental skills of listening, understanding, expressing empathy, asking open questions and reflecting. Unfortunately, research from the UK provides evidence that child protection social workers' performance of these core skills is sometimes limited. Forrester *et al* (2008) reported that social workers, in simulated role play, dominated conversation and relied heavily on the use of closed questions. These represent features of communication skills that are less likely to contribute to building a trusting and collaborative relationship. The challenge for the profession is therefore to ensure that students are equipped with the relevant knowledge and skills and that these are supported, developed and encouraged in practice, notwithstanding work pressure and time limits.

Service Users' Perspectives on Relationships with Social Workers

SAOL is a community project focused on improving the lives of women affected by addiction and poverty (SAOL, 2019: https://www.saolproject.ie/). Many of the women in the SAOL Project experience involvement with social workers e.g. in the context of child and family welfare issues, addiction issues or involvement in offences connected with drug use. In many cases, contact with social work and social services may be multigenerational with service users experiencing social work and social care in their own childhood. The women in the project are therefore in a position to give important insight into, not only the short-term relationship with professional helpers, but also the longer-term impact of such relationships. Underscoring the importance of relationship in practitioner education, the women in SAOL have been actively involved in designing and presenting educational input for student social workers. While this has focused predominantly on ensuring that social works understand and appreciate the issues that impact women around drug use, it also underpins teaching on the importance of relationship building (Loughran & Broderick, 2017; Loughran *et al*, in press).

At the IASW conference on *Putting Relationships First* (2019) women from the SAOL Women's Project presented a video in which they discussed their experience of relationships with social workers, family support workers and counsellors. The presentation was both informative and poignant. Although nothing can truly capture the impact of their presentations, we will attempt to reflect some of the insights they offered.

Despite exposure to social work/counselling in the past, service users reported that meeting new professionals was nerve wracking for them. One woman described her thoughts about a first encounter with social workers:

> *"I don't know what to expect, what questions will be asked, I might give the wrong answer, and will I be punished, will I be in trouble?"*

While practitioners might expect that service users who have been involved with services before may find it easier to engage, this is not always the case. One service user described a previous relationship she had with a counsellor. This relationship, she felt, was very positive, she learned to trust this worker, and felt understood and supported by the worker. Rather than assisting in the development of relationships with subsequent professionals this positive experience created its own problems. The service user had a sense of wanting the same relationship with a new professional, even though they recognised that everybody is different, and they were unlikely to have the same relationship again. Further complications arose when service users had multiple experiences of different workers over time. They recounted how it becomes more and more difficult to trust relationships, and to be prepared to be open when your experience has been that people in whom you have put your trust move on and leave you. Although the service users were realistic about the need for social workers and counsellors to move on with their own lives, they had a sense in which moving on was not given sufficient attention to facilitate coming to terms with the loss of the relationship. As one service user described it:

> *"you're only getting to know them when they go off, and you're fearful that the same will happen again and that a new person that you don't know will be less interested in you. It's very hard"*

Some of the women described the qualities that for them embody the development of a good relationship with social workers/ counsellors. In good relationships they believed that they could trust the person and rely on them, and because of this, they could share anything with them. More specifically the women described the importance for them of something as basic as good eye contact and were very clear about some examples:

> *"I would know if they were listening and if they were interested in what I'm saying because they would have eye contact. They wouldn't be writing what I'm saying and taking notes all the time. They would be listening"*

For the women a good relationship involved respect and not judging, noting the importance of practitioners treating them as individuals. One woman commented that years ago addicts had a bad name, and that many workers accepted this bad reputation and it got in the way of getting to know them. Apart from not judging them, respect also involved social workers turning up for appointments, checking in with phone calls, doing some research and having knowledge about what addiction/drug-related problems might be affecting them. Simply asking 'is there anything I can do' and giving some practical help was also seen as an important element of relationship building. One woman said she likes it when a social worker 'just pops in' to make sure she is doing OK and checking if they can be of any help.

Research suggests that service users describe positive relationships with social workers in the context of seeing social workers as friends (Beresford et al, 2008). The women in SAOL also talked about the sense that relationships with social workers/counsellors which were working well, are friendships. One woman described how she had a really good relationship with a counsellor:

> *"not only professional,*
> *but more like friends"*

She looked forward to meeting this person and had confidence that they would help her solve some of her difficulties, help her to feel safe enough to express her anger, and to give emotional support. Another woman described how she was heartbroken when her worker left, she felt let down and afraid of the future. When asked about this idea of friendship the service users were clear that although they use the term ‘friendship’ they didn’t actually see professionals in the same way as a friend, but rather use the term to describe the connection they felt with the worker and the worker accepting and listening to them.

The insights offered by SAOL service users support the importance of relationship building as part of social work/counselling/helping professionals’ role. They described the fears and expectations experienced in anticipation of first meetings with social workers. They also highlight the need to recognise that many service users have prior experiences which may influence their engagement in a relationship with the new worker. Importantly, new relationships may be challenging and difficult, even when previous relationships were positive. In fact, some service users described how having a really good relationship with the social worker/counsellor made it more difficult to engage with a different worker in the future.

The service users described with great clarity the basic counselling skills that social workers need to demonstrate in their engagement with service users: listening, being respectful and non-judgemental, maintaining good eye contact and being sure that their non-verbal/body language is congruent with demonstrating their engagement and interest in the service users’ story. The contributions of the service users particularly highlight the importance not just of beginnings, but also of endings in terms of relationships with social workers. This focus on endings may be something that social workers should pay more attention to, as it clearly has longer-term impact on service users’ engagement over time.

Listening to services users talking about the importance of their relationships with social workers and the challenges they experience is critical if social workers are to practice in an ethical and value informed way. The women identified that they were aware of power differences and this contributes to difficulties in both expressing themselves and in feeling listened to. The onus is on the professionals in this interactional relationship to take responsibility for using their skills to facilitate communication. Reemphasising the collaborative and advocacy roots of social work is part of this relationship building. The article will now look at what that further development of collaboration might look like by considering a case example from practice.

Relationships with Volunteers supporting social work practice:

Le Chéile Mentoring[1] Experience:

Over and above the social work/service user relationship, other relationships are key to ensuring positive outcomes. Le Chéile’s volunteer-based mentoring model offers young people a unique opportunity to form a relationship with an adult who is not a paid professional. The volunteers give their time each week to mentor a young person and focus on their individual needs and goals. O’Dwyer’s (2017) report on the service yielded interesting insights into stakeholders’ experiences of the programme.

> Youth Mentee: *“I liked a lot about him. He would listen; was always there; reliable, a*

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[1] Hereinafter referred to as Le Chéile

> *good friend and good support, a good help. He was just a great person, to be honest"* *(O'Dwyer, 2017:8)*

Le Chéile, a national children's charity, works to make positive changes in the lives of young people aged 12-21 years who offend, or are at risk of offending, and their families, through the provision of Youth and Parent Mentoring; Family Support; and Restorative Justice Services. Le Chéile provides tailored and flexible services with young people at the core. Le Chéile works in partnership with the Probation Services and the Gardaí to reduce the level of crime in the community.

The young people referred to Le Chéile have all been processed through the court system, charged with at least one offence and are normally on a Probation Bond – 2001 Children's Act. These young people are typically male, with an average age of 17, the majority are still living at home with a parent/guardian and not engaged in mainstream education (Le Chéile, 2015). Their offences primarily comprise public order, theft and criminal damage (IYJS, 2013). Many of the young people referred to Le Chéile present with low educational attainment, poor literacy skills, limited maturity, no male adult role model, bereavement and loss issues, mental health issues, negative peer influences and drug and alcohol misuse. Furthermore, many of the young people referred come from minority groups, for example the Traveller community, who may have had negative experiences engaging with agencies in the past. In addition, their parents/guardians can be struggling with their own issues such as health concerns, drug/alcohol issues, housing or financial difficulties. As a result, it can be challenging for young people to engage with an adult mentor and they may resist the service in the early stages of the mentoring relationship.

The Le Chéile mentoring model operates within a restorative practices framework. It encourages mentees pro-social behaviour, positive behavioural change and participatory decision-making.

> Probation officer: *"A Le Chéile mentor does not focus on the negative behaviours of the young person and this can be a 'breath of fresh air' for the youth person"* *(O'Dwyer, 2017:5).*

This is essential in the engagement (initial) stage and throughout the mentoring relationship. Restorative practices involve all parties coming together and focuses on participatory learning, gaining a greater understanding, decision making and putting things right (Watchel, 2013; Zehr, 2002). Le Chéile mentors are encouraged to work with young people throughout the process, allowing for effective relationship building and encouraging both parties to work together towards agreed goals. Through the process, mentoring provides the necessary support and encouragement whilst ensuring appropriate levels of control are in place. This allows for effective relationship building and empowering young people's participation when working with volunteers and/or social work practitioners.

Le Chéile is committed to using programmes and approaches which result in better outcomes for children and young people. Better Outcomes, Brighter Futures: The National Policy Framework for Children and Young People 2014-2020:3, states that:

> *To be effective, policies and services must be evidence-informed, and outcomes*

> *focused. (Government of Ireland, 2014:21).*

Le Chéile commissioned an independent evaluation and social return on investment analysis in 2016. A range of stakeholders took part in the evaluation, including young people and parents who were mentored, volunteer mentors, Probation and Le Cheile staff and other significant professionals. The research methodology consisted of both qualitative and quantitative methods, including face to face interviews, focus groups, surveys and case file analysis. The final report "Reducing Youth Crime in Ireland: An Evaluation if Le Cheile Mentoring (Dr Kieran O Dwyer 2017) can be accessed https://www.lecheile.ie/wp-content/uploads/2017/03/Reducing-Youth-Crime-In-Ireland-Executive-Summary.pdf

O'Dwyer's independent evaluation of the service and social return on investment analysis (2017) identified key outcomes of the programme:

- Le Chéile mentoring reduces youth offending by an average of 28%.
- The biggest overall gains for young people were in the areas of self-confidence, hopefulness, communications and engagement in positive activities.
- Significant positive impacts were also noted for parents who engaged in Le Chéiles parent mentoring services. These include improved self-confidence, ability to manage stress, improved parenting skills and over all a better relationship with their child.
- The significant role of volunteer mentors, supported by Le Chéile staff, emerged as an important strength of the programme for both young people and parents.
- The evaluation concluded that every €1 spent on mentoring returns €4.35 in social value. This represents a significant return on investment and is a clear economic endorsement of mentoring in the field of youth justice.

In terms of social work professional practice, working in a voluntary capacity is something that cannot be overcome when one is in paid employment to work with a young person. However, Le Cheile's relationship with its statutory partner, The Probation Services, is also a key to the successful engagement of young people in that both agencies are required to be clear with the young person regarding their level of involvement. Young people still have a choice to engage with services and it is important for practitioners to encourage informed choice amongst its service users.

> Mentor: *"Le Chéile recognises and supports its volunteers better than any other organisation I have worked with. I think this is evident by the enthusiasm and commitment it receives from its volunteers" (O'Dwyer, 2017:28)*

To build effective, strong working relationships that transform lives, requires good quality training and supports for volunteers and staff alike, whilst promoting good communication between all parties involved. Working in partnership with key agencies within the community, voluntary and statutory sectors is undoubtedly the key to building relationships and put relationships first.

Taking a further step in developing collaborative relationships with service users leads us to consider how to address the ways in which social workers and service users can work together to capture the voice of the service users and to promote that voice in the context of what works and how services should be shaped to best fit the needs of service users. This inevitable bring us to the role of research in social work, and specifically to ways in this the collaboration between service users and social workers can be embedded in research practice.

Collaborative Relationships in Research: Co-production

Looking beyond therapeutic relationships, the benefits and potential of other social worker/ service user relationships are garnering significant attention.

> *Some social workers have criticized traditional research approaches, suggesting that they are not consistent with the profession's mission to serve vulnerable and disadvantaged populations … an appropriate alternative that is participatory, empowering, and committed to social justice [is required] (Branom, 2012).*

One of the marks of quality in research is gathering information from different perspectives to get the best overview of the phenomenon. This might involve gathering information from practitioners and service users, and perhaps family members, in order to maximise understanding of the impact of a service. *Participatory research* takes the idea of different perspectives to the next level, by engaging a broader range of people in research, not only as informants, but as co-researchers. Therefore, the valuable insight derived from lived experience informs the creation of research, according more agency and situating service-user voices at the centre of analysis and understanding (Denov & Shevell, 2019).

There has been a growing interest in participatory research over the past-two decades, and increasingly service-user, consumer or public involvement in the research production process is a mandated requirement of research funding. Notwithstanding this, participatory research remains relatively uncommon within social work.

What is participatory research? This type of research, rather than focusing on the knowledge outputs of the study alone, also focuses on the roles that the researchers play in the research process. Specifically, this type of research is interested in the roles service-user researchers play as part of a team of practitioner or academic researchers. Involve (2012) defined participatory research as research that is done 'with' or 'by' service users who are active involved in the research process, rather than 'to', 'about' or 'for' them as research subjects. It is worth noting that there are further types of research e.g. user-controlled research or emancipatory research, which involve service-users more extensively in the production of research. However, these are not addressed here, as they fall outside the remit of social work research.

Participatory research is a type of research, it is not a research method. As such participatory research addresses who is involved, how they are involved and how the project is managed and run. Once these decisions are made the resulting team will decide how the questions will be framed and how data collection will be undertaken. The team may employ any range of appropriate methods such as surveys, interviews, or focus groups to garner the information they need.

Who is involved in participatory research? The principle of participatory research is co-production, which by definition includes service-users working alongside practitioners, academics or researchers to design, undertaken and produce research outputs. The research team can also draw on the skills of others, such as community members or contract researchers. The tasks to be undertaken by service users, practitioners and/or academics are typically negotiated at the beginning of a research project. Service users can have a role in initiation or designing of the study e.g. advising or planning how the project will progress and what questions it will address; a role in recruitment of respondents; a role in data collection, perhaps as peer researchers; a role in analysis and interpretation of data; and/or reporting and disseminating output. Participatory research can include various degrees of service user involvement at each stage in the process.

Service users are less commonly involved in the initial conception of the project and applications for funding. Although perhaps not ideal, it is more typical for service users to be co-opted once these early tasks have been secured. Some studies will engage service users at every stage thereafter, in either a collaborative or partnership role. Such studies are truer to the principle of collaboration than others may be.

Regrettably, one of the risks of participatory research is that service-user involvement can be tokenistic, with little real decision-making power afforded to service users. Other challenges associated with participatory research include a higher level of planning, negotiation, support and training than might typically be required when the researchers are experienced (Loughran & McCann, 2015). These augmented procedures can make the project lengthier and more time-consuming, which may have associated resource implications. Writing critically about the practical realities of participatory research in social work, D’Cruz and Gillingham (2017) point to the use of mindfulness and reflexive practices by researchers as strategies which can help navigate the tensions in the process.

Notwithstanding these challenges, proponents of participatory research, argue that the benefits of service-user collaboration in the production of research are significant. Empowerment derived from power-sharing and equitable decision making is held up as the principal benefit. Co-production also yields dividends of co-learning and capacity building for all partners. By focusing on the value of the process as well as the products of research, participatory research has a strong action element, striving to have social impact not only through outputs, but also through engagement of service users in creating the social impact. D’Cruz and Gillingham (2017) argue that from a rights perspective, participation is an end in itself, as well as a means to an end.

Returning once more to the quality of research, a participatory approach, notwithstanding it’s challenges, holds many advantages. Embedding ‘expertise by experience’ can afford a more nuanced, applicable and valid framing of questions; a more topic-sensitive, ethical and relatable data collection team; better access to the target population; a more informed and higher level of relevant data interpretation and reporting with greater face validity; and, as McLaughlin suggests, very powerful dissemination, with audiences hearing the results and recommendations of the research directly from those who have lived experience (2010: 1599).

Despite its clear advantages, participatory research remains as yet, an uncommon social work research approach. The challenges associated with this approach add another layer of complexity to the task of researching. However, arguably, it is one of the few approaches to research that truly reflects the social, egalitarian and empowerment principles of social work building on the relationships of social worker and service user. There would appear to be strong arguments for inclusion of participatory research in social work education.

Conclusion

Service users clearly articulated that whatever the context, spending time on building a connection is critical for positive work and positive outcomes. The future focus on relationships in social work needs to be threefold: Firstly, social work education must emphasise the importance of integrating the knowledge base of social work with the development of excellence in core counselling skills, participatory research skills and familiarity with co-working opportunities. These are fundamental to building collaborative relationships with service uses and with other professional disciplines. Secondly, social workers need to ensure that they clearly demonstrate their proficiency in these skills in their interaction with service users, while employers need to support this through provision of continued professional development and supervision. Finally, the voice of service users' needs to be, not just heard, but actively listened to. This is required not only in one-to-one interaction but in a wider sense of service users collaborating in, and indeed leading on to research to inform social work practice.

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‘OBJECT POVERTY’ PRESENTED AT THE IASW NATIONAL SOCIAL WORK CONFERENCE 2019

Author: Gary Broderick, Jane McNicholas, Ray Hegarty and the SAOL Project Participants

Gary Broderick, Jane McNicolas and Ray Hegarty are staff members in SAOL; Ray is also a socially engaged artist who creates most of his work through the medium of photography with groups who are often socially excluded.

SAOL is a project for women with addiction issues and offers an integrated programme of education, rehabilitation, advocacy and childcare. The SAOL Project’s on-going commitment to the women, children and community members of the North Inner City continues to develop, responding to the changing needs of the women who participate in our project with creativity and commitment. SAOL has worked over the last 23 years to promote the needs of women who use drugs and their children.

Introduction

In July 2016, in preparation for October 17th UN Day for the Eradication of Poverty, the Saol Project made contact with a broad group of people and asked them a simple question: What 3 objects do you associate with poverty? We thought it was a simple question, but many people were very puzzled by it. Everybody knows what poverty is. But when asked to move from their idea of poverty to envisioning it as something concrete, many struggled to find its form.

Nonetheless, 230 responses were gathered and from those we created a list of the top 16 answers. We chose sixteen images because that number is visually pleasing, and this research was to assist us in creating what would become ‘Object Poverty’. Once we had our list, we created a visual representation for each object. For some objects that was easy: A sleeping bag, a paper cup, an empty purse. For some, we had to think ‘outside of the box’. For example, ‘no food’ became an empty dinner plate; no home became an uncut door key; bad teeth or poor dental hygiene became ‘a toothbrush’. Each image was printed to a size of approximately 1m x .75m and was then framed in an old ‘bread board’ that we sprayed gold. We liked this idea because of the phrase ‘living on the bread-line’; it seemed a perfect fit for Object Poverty. (The fact that the bread boards were donated to us had nothing to do with where the idea came from!

We displayed ‘Object’ Poverty’ in a local community centre and then, with the help of a builder who had erected wooden hoarding around a house he was renovating, had a ‘street exhibition’ on Amiens Street.

What we discovered was that as people saw the images, they tended to have a sad reaction to them and then began to tell their own stories, recalling the memories that were triggered by the images. One woman spoke of the cold she felt when her heating didn’t work, and she needed her hot water bottle. A man told us of the shame he felt when he couldn’t afford all the things, he collected in his shopping basket in a supermarket. Another told us of the pain in her feet from walking in the wet and cold because she had nowhere to stay during the day.

We decided to bring ‘Object Poverty’ further and made contact with some of Dublin’s universities. The deal we struck is that SAOL’s participants would come and tell students about this project and the students would be invited to share their interpretation of the objects displayed. What was brilliant about this was that our SAOL participants began to blur the line – were they ‘helpless people caught in poverty and addiction’ or ‘powerful women teaching university students’?

As our programme of events developed, the groups going from SAOL became stronger and more vocal in their demands that these ‘new professionals’ understand that poverty and social isolation is a critical element in holding people back from making positive changes in their lives. They spoke out demanding that lazy interpretations or explanations that people who are poor are ‘not motivated to change’ was an unacceptable interpretation of what is happening in our countries and that societal responsibility for the communities that are created is necessary.

And each of the objects began to be a rally call for different issues:

- The button, which hangs on by a thread, originally represented ‘poor clothing’ but became the image for ‘mental health/ stress and an unequal health system’

- The ‘needle’ moved away from representing addiction and became the symbol for ‘life-saving access to health care’.

- The coffee cup which initially represented ‘begging’ (people using the paper cup to beg on the streets for money) represented the ‘relative price of food’ with people realising that the money paid for a cup of coffee could pay for breakfast for a family for a few days.

So far, we have been to Dublin City University, University College Dublin, Trinity College Dublin, Maynooth University and Liberties College and Griffith College. It was part of the Five Lamps Festival in 2018. We have also been to the European Parliament in Strasbourg, Council of Europe in Strasbourg, University of Warsaw; and on 17th October 2017, Dáil Éireann. The latter visit required that we prepare a presentation on Object Poverty and that began a process for what was to become the reflection that our participants presented at the IASW Conference in May 2019. We are very happy to share that presentation with you here. The reflection on each of the images is a collection of thoughts gathered from all of the feedback we have received while sharing Object Poverty with the general public and all of the students we have worked with over the last three years; while also being a process that was initiated by the experience of the SAOL participants to begin with. Please feel free to share these thoughts and images but please reference SAOL Project and Ray Hegarty (photographer/artist) when you do so.

The Objects

Sleeping bag

I am the sleeping bag.

I represent the very visible face of homelessness – the rough sleepers. There are about 156 such people in Dublin each night.

The less visible face of homelessness are the 10,253* sleeping in emergency accommodation. This includes all the hostels and all the B& Bs where men, women, children, students, are packed into rooms.

One such story from a family of 4. They are Polish. Both parents work and their two young sons are in school – 6 days a week - because they attend Polish school on Saturdays. They have been living in 1 room in a B & B for over 3 years. They have a microwave and a kettle. They share a bathroom with 6 other families. The boys play in the corridor, but quietly because their mother does not want them to get into trouble. The older boy is starting to show signs that this way of life is damaging. He cries a lot, doesn't talk much any more and is usually angry with his parents and brother.

The family has one small double bed and one single bed and whichever combination they try, nobody really gets a good nights sleep. They have a sleeping bag too.

Almost one in five homeless people are in employment, according to the latest update from Irish Census 2016.

The CSO also found that almost 1/3 of non irish people in Ireland are homeless (Irish Times, 2018)

* https://www.focusireland.ie/resource-hub/about-homelessness/

Boots

I am a pair of boots.

I don't have a label.

These boots belonged to a woman who has been homeless for over 20 years. Her name wasn't properly registered on the homeless list.

The woman spent a lot of her days during this 20 years walking about so needed thick boots.

To begin with she lived in a tent because she could not get her head around living in a hostel. When she lived in a tent she walked around for most of the day because there was little else to do.

She moved to hostel accommodation when she got too tired of living in the tent. It wasn't an easy move.

Being on the Free phone means you can only ring up after 2.00pm and even then you might not hear where you could get a bed until after 8.00. Bad days were when she only heard where there was a bed at 10.00 at night. That was a lot of walking about to do.

Some of the hostels put everybody out at 9.00 in the morning and they could only come back at 6.00. Even when she got pneumonia she was out walking the streets. Boots were her preferred footwear as they kept her slightly warmer.

Other hostels let you stay in all day but that is difficult too because you start to lose track of where the days are going and even when it is day or night – especially when there are no windows in the hostel dormitories and you can't see the sky. It made her think she was losing her mind. You had to sleep with your boots in your bed too because otherwise they might be gone when you woke up.

Pill

I am a pill – an Upjohn 90 to be exact.

I represent addiction

I am both prescribed and un-prescribed, but either way I am easy to come by if you know how.

I am prescribed and taken to ward away ‘excessive anxiety’ .

There are so many ways to get this anxiety.

You might have it because you have lived most of your adult life trying to get by with just enough to go around. That’s not enough food, not enough space, not enough kindness, not enough care, not enough health.

You might get this kind of anxiety if you have become caught in a relationship that is violent and abusive. You stay with your partner becuase you’re afraid to leave, but the pill makes it a little more bearable. It means you don’t quite feel the despair quite as intensely.

You might have this anxiety just because you find life a struggle. Going out is scary, bills to pay is scary, night time and the dark is scary, some of your neighbours are a bit scary – and you don’t quite know how to handle it all. Taking a pill seemed like a good idea at some stage.

An empty purse

I am an empty purse.

I represent a lack of money.

According to the National Anti-Poverty

Strategy: “People are living in poverty if their income and resources (material, cultural and social) are so inadequate as to preclude them from having a standard of living that is regarded as acceptable by Irish society generally.”

Social Justice Ireland report that most weekly social assistance rates paid to single people are €30 below the poverty line. If your purse is empty you tend to worry about a lot more things for a lot more time. It doesn’t matter whether you are working or not*.

You worry about things like Christmas and birthdays and back to school and communions and the summer holidays and keeping the children occupied and winter and keeping warm. Because if you have an empty purse all these things are a cause for worry rather than celebration.

It’s hard to save when there’s nothing left at the end of the week. You can always borrow but that often doesn’t end well and is further cause for worry.

Too much head space goes into trying to figure out how to make things work. Trying to work out an impossible sum ‘how to save something from nothing’ makes you worn out – all the time.

An uncut key

I am an uncut key.

This means I will not be opening any doors for anybody.

Not having a home makes life difficult

When you are homeless there seems to be an endless line of closed doors. You do have some choices though.

You can sleep rough and take your chances with the weather and the streets.

You can go on the Freephone and take your chances with the hostels – single rooms, dormitories, night cafe floors, no-door rooms.

You can take your chances with the HAP scheme. There’s lots of closed doors here if you are poor and on benefits. Even if you

20% of adults in Ireland and living in poverty are in employment and/or education manage to get access to Daft.ie or MyHome.ie and secure a viewing on a suitable property, you are almost guaranteed that there will be many other people in the queue to view alongside you. And some of these people will have car keys and can get to see the property with relative ease, while you have to take a bus and try to get as close as possible so that you dont have to walk too far. And because you have run out of credit on your phone you possibly will get lost and give up on that days endeavour and so not even get to see the property anyway. But even if you do see it and it suits and you leave your name and contact number with the landlord, you still have to hand him the HAP form to indicate that you will be needing to avail of this scheme because the rent is way too much to pay from €203 per week – all of that money wouldn't even cover the rent. And as you hand the landlord the form you guess that your name has gone to the bottom of the list and the car-key holder is in front of you again.

Final chance is with the local housing council – and for that chance you just have to sit it out until you think you can sit no more – and then maybe you will get lucky and the key may be cut.

* https://www.citizensinformation.ie/en/social_welfare/social_welfare_payments/unemployed_people/jobseekers_allowance.html

Paper Cup

I am a paper cup

I could have come from one of the many coffee shops that have spread across our cities and towns. Here you can get free wifi, warmth, gentle music, wooden bookshelves with wooden decorations, histories of coffee making, illustrated walls, as many serviettes as you need to take and reasonably clean toilets. You can also get hot chocolate, hot chocolate with cream and marshmallows, chai latte, speciality latte, cappucino, double shot espressos, macchiato in any size, with any flavoured syrup…and all for just €3.65*.

€3.65 is what it might cost you to feed yourself for a day if you are smart and of course if have some means of cooking (even just for toast and a pan for the beans will do). Then €3.65 will get you a loaf of bread (79c), tea bags (89c) tin of beans (49c), litre milk (75c), bar of chocolate (65c). Beans on toast, tea and chocolate what more could you need?**

It’s tempting to spend it all on the paper cup of coffee, and sit on the sofas and listen to the music and be warm, and feel like everybody else – but that doesn’t always work for you, because being poor you don’t feel like everybody else, and you certainly would feel too embarrassed to ask for the code to use the toilet and the person behind the counter does not smile at you.

The paper cup can also be used for begging – should the need arise.

* Starbucks, Dublin 2018/Lidl 2018

** The remaining balance of 8c can go towards the cost of the electricity used to boil the kettle, heat the beans and make the toast.

Soap

I am soap – specifcally carbolic soap. You need a strong soap to get things properly clean.

This particular bar came from one of the Magdelene laundries.

The laundry is in a poor part of town and the surprising thing is that it still goes largely unnoticed by the poor people who pass by. The dirty redbrick exterior blends in with the dirty street. The black crosses on the railings should be enough to draw attention, but they usually don’t.

Sometimes the most obvious things in our midst like the laundry, like poverty, are not seen and are not really talked about. In real language. And that is a big part of the problem

Another surprising thing is that such a dirty building as the laundry was once solely designed to keep things clean – the laundry - and the image of Ireland as a god-fearing country.

But there are parts of Irish history that cannot be washed out even by carbolic soap.

‘Roll up’ cigarette

I am a roll-up.

I have no label, and am much cheaper than a packet – even those you can buy off the stalls.

They are not healthier than cigarettes but people who smoke roll-ups are not doing it for their health. You can get a lot of roll-ups out of one pouch, and when it starts to run out, you can make the rollies ever more straggly until you’re down to the dust.

If you are poor, smoking roll-ups makes a lot of sense (if you think about this in a particular way).

Smoking wards off hunger – so it really is a money saving habit. If you don’t feel hungry then you don’t need to eat as much.

Smoking is a bonding activity. You belong to the group with all the other smokers around you. When you’re poor, there’s not many groups that you really belong to, so it might as well be the smokers.

Smoking is a sociable activity. There’s endless opportunities to ask for a light, to have that interaction with another human being. Standing smoking together you can chat about what’s going on.

Smoking calms you down when you’r feeling a bit rough. Waking up in the morning without money, without much of what you want, you could still have your roll-up, and life might not feel so bad. They can make you feel like you’re more in control (even though you might know that you’re not).

Plate

I am an empty plate.

Hunger is an empty plate

If you eat off plates then you probably also have a table to put the plates on. And that conjures up pictures of families sitting around the table eating together.

When you are poor that seems to happen less. It's not that it's not important but if you live in a hotel room then you probably don't have a table. You might have plates and you could sit on the bed together to eat toegther but that's not the same.

When you are poor some of the 'normal' traditions of families get lost in the daily struggle of how your life has become. If three generations of the same family are living in the same three-bedroomed house – that's 14 people – then your normal is very different from the' happy picture normal'.

Your normal is sharing your single bed with your 3-year old son, with that single bed in your mother's bedroom. And your mother snores so it is difficult to fall asleep. And if your son wakes up early you have to keep him very quiet otherwise everybody gets mad before the day even starts. You can't go to the sitting room because that's now also a bedroom for your sister, her partner and their baby.

And if you don't get on with your family then you try to stay out of the kitchen as much as possible to avoid the conflict, so eating off plates becomes a non-essential way of living.

Toothbrush

I am a toothbrush. I keep your teeth clean.

I obsessively clean my teeth. After every meal and cup of tea (when I can). I don't care who sees me in the project. My toothbrush and toothpaste come with me wherever I go.

I try to keep my teeth looking well. They are your immediate introduction, the window to your social standing. Stained, blackened, missing teeth mean bad, scary, addicted, poor person; clean, shiny white teeth mean good, trustworthy, healthy and wealthy person.

I keep my teeth clean, but I cannot afford to go to the dentist. They only want to take out your teeth anyway; fillings and dental work cost too much for people like me.

But every time I look in the mirror, I see what you see, and it hurts me. Sometimes I avert my eyes, so I don't have to see what you see.

My teeth are not good, but they are teeth and not a description of me. I am kind and honest and clean and caring; I just cannot afford to have shiny teeth.

Don't judge me because of my teeth.

Cardboard

I am cardboard.

I am discarded; once a protecting box for an expensive item; now thrown away but useful one last time – as insulation and cushion from the cold relenting concrete of the city pavement that now acts as bed and bedroom for those we call 'rough sleepers'.

I am cardboard; shaped as a Euro symbol but I am worthless.

I am a 'rough sleeper'; noticed only when Christmas comes around or when the wind blows too strongly or when one of our number dies near the Dáil.

I am one of 158; one of those who is counted twice a year. I am a number and my importance depends on whether the number goes up or down. If it goes down then you have successfully made an impact on an intractable problem; if it goes up, like successive governments you promised much but have done so little.

And yet here I am, a rough sleeper, a face and a name behind the number. I am pissed on and spat at and offered advice by the drunken passers-by; I am avoided and pitied and tut tutted at by the workers on their way to their offices. They will step onto the road as they pass in case they might catch something from me.

After all, the average lifespan of homeless men in Ireland is 42

And when I die on the streets (and I will die), I will die quietly, frozen in time; and you will say that your outreach workers contacted me many times but I did not want the beds you offered.

And I will be dead.

And your numbers will go down by one.

Hot water bottle

I am a hot water bottle

I was patented in 1903 by Eduard Penkala, a Croatian man who created a thick rubber bottle bed warmer that reduced the risk of burns.

My gran had a hot water bottle and I learned how to fill it when I was a child. I often needed help to untighten the stopper; and then, after pouring out the cold water, I would fill the bottle half way with boiling water from the kettle on the range; and then, after squeezing it a little and letting some of the steam release, I would carefully flatten the ‘empty half’ of the bottle and put the stopper back in. I would then proudly present it to my nanny; she would check the stopper and then wrap the bottle in a pillowcase; and then she would give me a toffee of my choice.

I have a bed and a hot water bottle myself now. But somehow it seems ok to tell stories about my gran but shameful to say that 40 years on and I have not progressed. My life was to be so different; yet I am the same as her.

But she owned her house; and her bed was properly made and not a throwaway Ikea DIY construction; she had heat in the range the whole of the day and not a barely used heating system that costs too much and leaves the place cold as soon as it goes off.

I used to look at my nanny and knew that my life would be better than hers. I love my nanny but her life casts a judgement over me. I have less than she had. How can that be?

I think of my nanny now and wish for the home that I cannot give my own children – its warmth, its hearth, its security.

I along with 400,000 other households do not have enough money for heat in Ireland.

I am a hot water bottle.

Do not judge me.

Hypodermic needle

I am a hypodermic needle

Don’t judge me.

You might see plenty of these spikes littered around the derelict buildings. They look dangerous. You wouldn’t want a child to pick them up. You wouldn’t want a child to even see them.

And they are dangerous. And whoever picks them up and uses them to inject heroin is inflicting a harm on themselves. It’s not that the person doesn’t know what they are doing but they probably don’t think of the harm, or the ulcers and abcesses and broken veins.

You wouldn’t want a doctor to see these ulcers and abcesses and broken veins because they fill with you shame.

But doctors also use these hypodermics needles so you might also see them in a hospital. Not everybody gets to hospital when they need to. For example if you are can't attend appointments then it is very likely you will slip through the health care system with an ease that is not matched by your life or your health.

Keeping appointments is difficult when you have no stable address to inform you about appointments.

Keeping appointments is difficult when you feel too embarrassed to talk about your body.

Keeping appointments is difficult when you are a mother and you are afraid that if anybody medical notices that you are poor then they may start asking difficult questions and take your children away.

Button

I am a button.

I am attached to old clothes; functional, glamour-less and dated. I used to be stylish and shiny and new; but fashions change before the clothes wear out. Business needs that; the need for new before the old has worn out.

But I cannot afford the new; or the new that I can afford is not warm enough for the winter days and nights.

I am a button.

I am hanging by a thread. I am holding in there – just about. Clinging on. Will you miss me when I can hold on no more? Or am I just another one, another negative side effect of big business. The mental illnesses of the poor who cannot keep up with the speed of modern

Irish living.

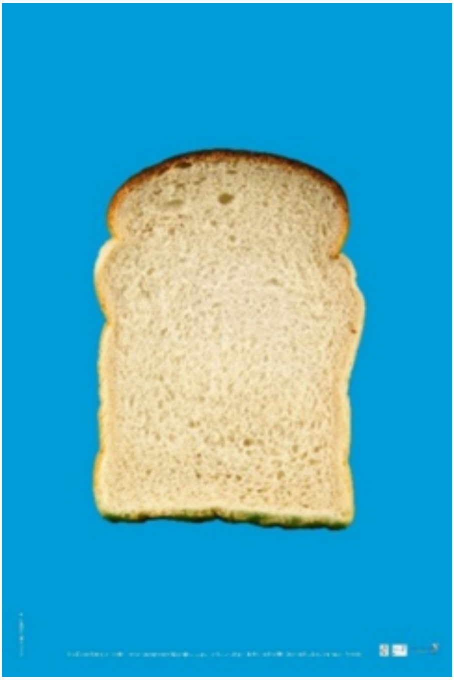
Worn out before adulthood.

Our friend, Jenny, a mother, a gifted designer, creative and loving, funny and joyful; she was as bright as a button, but she couldn't hold on anymore. She died in August and we miss her very much.

We tried but when group members are just about holding on themselves, it all becomes too much. When what causes the thread to weaken is a combination of things (and not just one straight-forward issue) it becomes harder to hold on.

Poverty and addiction and mental health and trauma all combine together to form a heavy load. A single, weakened thread will always break under such a heavy load.

Bread



I am a slice of bread.

I am the barest minimum food to get by; I am a snack; I am essential when you're hungry and then easily forgotten because I do not last too long.

Hunger eats at your confidence and your sense of self. Good people don't get hungry and can't do anything about it, do they?

I go to work hungry, regularly. I feed the others – the children, my partner, my mother and mother-in-law. When there's not enough, I tell them I'm not hungry and leave my plate empty. A smoke bats the hunger a way for a while.

It makes me ratty in the morning – waking up hungry (at my age) – and so I have a tea and a smoke and get the kids their breakfast – I make the milk stretch as far as it can – and go into work. I can't concentrate on my classes knowing that break is coming and it's then that I can eat. I wish my first hour away.

Then I'm embarrassed eating in front of the others; I don't want to be seen to be eating too much and set the tongues wagging.

They make loads of toast at work. Slices of bread piled up on the plate. Eat as much as you want. And then, for health and safety, any that're left get thrown away. It's a mad world, not enough bread in one kitchen and leftovers in another.

Empty Basket

I am an empty shopping basket.

This is the first thing that you have to pick up when you go into a supermarket, and even though it is empty the weight is heavy on your mind as you try to work out how to fill the basket today.

When the everyday task of going to the shop is a stress then you know that you are poor.

When you can't afford to buy in bulk, and so always pick up a shopping basket and never get a trolley, then you know that you are poor

When you don't have transport to go to the bigger supermarkets (on the edge of town) then you know that you are poor.

And when you are poor you are hit twice because you end up paying more money for less things. It's a lose / lose situation. It's actually worse than lose / lose because there's a third loss with poverty, and that's because you also lose the choice of buying things that you might want and you might like. You don't pick up the strawberries or the organic spinach or the finest cheeses or the luxury homemade, whole grain bread. They are too expensive, so you get the white toastie bread again.

The original term ' basket case' was used during the First World War to describe soldiers who had lost all four limbs. Poverty is just as debilitating

All women with any addiction issue are welcome at SAOL; people can self-refer and will be seen on the day that they knock on our door. Professional referrals can be made by accessing our referral form from our website www.saolproject.ie. Please contact us if you would like to know more or indeed come and visit us to see what we do.

Voice recordings of the presentation can be accessed at the following link: https://www.saolproject.ie/UNDayfortheEradicationofPoverty2016.php

INCORPORATING THE EU VICTIMS DIRECTIVE INTO THE ASSESSMENT OF RETROSPECTIVE DISCLOSURES OF CHILDHOOD SEXUAL ABUSE.

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Abstract

Irish social work practice in respect of retrospective disclosures of childhood sexual abuse is an area which has garnered increasing critical attention over the past decade. This area sees social work practitioners foisted into an intricate negotiation of personal and legal rights and obligations and delicate Constitutional balances all within the context of childhood abuse, trauma and potential risk. This paper draws upon a narrative study conducted with adults who have disclosed childhood abuse to child protection social work services in Ireland. The paper draws correlations between what those adults said would have helped them through this process and current European Union law which offers a framework within which to provide such elements. Considerations and recommendation for social work practice, policy and law are drawn and discussed.

Keywords

Child protection; child sexual abuse; disclosure; social work law

Introduction

Disclosure of sexual abuse can be an extremely difficult and, in some instances, an insurmountable task. Disclosure is best viewed as a dialogical, fluid, inter-relational and life-long process that can take many forms and begins at the point of abuse with increasing likelihood in older youth and adulthood (Alaggia, 2004, 2005; London, Bruck, Wright, & Ceci, 2008; Hunter , 2011; Collin-Vézina, De La Sablonniére-Griffin, Palmer and Milne, 2015; McElvaney, 2015; Reitsema & Grietens, 2016). There is a tendency to delay disclosure (London, et al., 2008) with many withholding or unable to disclose until adulthood; for some disclosure does not occur for a variety of reasons. During the *Sexual Abuse and Violence Study* (SAVI) conducted in Ireland in 2002, 47% of those who had experienced sexual abuse in childhood had not told anyone until they were asked in the interview questionnaire (McGee, Garavan, de Barra, Byrne, and Conroy, 2002). International research also suggests that rates of disclosure of childhood sexual abuse to a State authority are even lower (Leventhal, 1998; Collin-Vézina, et al., 2015). This hints at the possibly large, hidden population effected by sexual abuse in Ireland and also the potential hurdles that must be overcome in other to disclose.

Retrospective disclosures have been

described as: “disclosures by adults of abuse which took place during their childhood”, this definition has been used in Irish child protection policy and practice since 1999 (Department of Health and Children, 1999: 39). Under Section 3 of the *Child Care Act 1991*, in addition to the recently updated *Children First National Guidance for the Protection and Welfare of Children* (Department of Children and Youth Affairs, 2017) the response and management of such referrals by child protection social work services has been developing over the past two decades. This has occurred within the context of significant legal challenges by way of judicial reviews taken by those accused of committing such abuse (Mooney, 2018; Department of Children and Youth Affairs, 2019) and other issues highlighted by State and independent bodies such as delay, mismanagement, and poor oversight of retrospective referrals (Office of the Ombudsman, 2017; Health Information and Quality Authority, 2018; Mooney, 2018). The first academic research conducted with social workers and other professionals in respect of retrospective disclosures, published in the Irish Social Worker in 2014, highlighted a lack of specific practice guidelines, policy and direction for social workers engaging, at that time, with retrospective disclosures (Mooney, 2014). In that study social workers highlighted ‘personal sensitivity but professional helplessness in respect of their role and the procedures to be followed’ (Mooney, 2014: 10). Considering these foregoing complexities alongside the possible dynamics created by an experience of abuse and subsequent disclosure, the aim of the author’s PhD research, outlined within this paper, was to ascertain what is it like for adults, who have experienced sexual abuse in childhood, to make a disclosure via this system; disclosures which serve to expose potential risk to current or future children in our communities. This aim encompassed three central research questions: (1) What are the facilitators and barriers for adults making disclosures of childhood sexual abuse to child protection social work services; (2) How does the current disclosure process within the child protection system and its underlying policies take account of the specific needs of adults who have experienced child sexual abuse, and (3) What are the policy recommendations that can inform social work practice in this area?

Methodology

Biographical Narrative Interviewing Methodology (BNIM) was used to gather the adult’s views and experiences of making disclosures to child protection services. BNIM collects data by posing an open, narrative-inducing, question (Wengraf, 2001). Following this the interviewer does not prompt, direct or affirm the interviewees response and is restricted to posing some follow up questions once the interviewee has exhausted their initial narrative. The process affords much of the control of what is said, and sometimes more importantly what is not said, to the interviewee. Given the dynamics of power and control that often accompany experiences of abuse, BNIM is a useful method to adopt in the context of researching child sexual abuse and disclosure of same (Mooney, 2019). Five adult participants were recruited via an agency called One in Four who acted in a gate keeping capacity. The agency provides therapy, advocacy and support to those affected by sexual abuse and all interviews were conducted at their offices. This was done in order to provide follow up support to participants where needed. During the wider research the term ‘adult who has experienced sexual abuse in childhood' was preferred to either 'victim' or 'survivor', this allows those participating and those reading to identify as they wish. This article involves a review of the *EU Victims Directive* and as such the term 'victim' is used in this context. Data were analyzed by the author via NVivo 10 software and a BNIM panel analysis method (Wengraf, 2001; Mooney, 2019). Each participant was attributed a code following their interview and this was later ascribed a randomly selected pseudonym (used here). Exclusion and inclusion criteria were used to recruit the sample for this study, informed consent was sought from each participant and the entire study was granted ethical approval by the Research Ethics Committee at NUI Galway. These interviews were conducted in 2015 and while social work practices and process have developed since this time the core complexities and problematic issues remain, preserving the relevance of these findings for current social work practice.

Overview of Main Findings

Three main themes were identified from these data: (i) the system as a barrier, (ii) issues of power and, (iii) the system as a facilitator. The first of these was a sense that the participants found the system as a whole to act as a barrier to disclosure. Issues presented here related to a perceived lack of training, expertise and professionalism in respect of social workers managing allegations of sexual abuse. These negative experiences were very often caused by larger system failures to provide guidance, policy and practice direction, as opposed to failings of the individual social workers themselves. One of the participants, Jane, went so far as to highlight the good work being carried out by social workers: *"… sitting in the, the waiting area, it really brought home to me the context of the type of work that they do, you know, that's why that had such an impact on me… I as just like, these people are amazing to be doing this kind of work…"*. Despite this general view, participants often highlighted that the practitioner they met with seemed lost or confused when it came receiving and processing their retrospective disclosures. Within the second theme there was a prominent sentiment among the adults that the dynamics of disclosure and abuse were not fully appreciated with the dynamic of power being significantly under-appreciated within their interpersonal interactions with social workers. Power is a significant facet of an experience of sexual abuse, especially in childhood (Death, 2013; Bell, 2011; Hagan and Smail, 1997, Keenan, 2013). Aspects of power can manifest in many forms for those adults coming forward, for example in terms of the nature of the abusive experience, memories or recall of same, within the adult's wider familial and social structures and, for the purposes of this study, engagement with a statutory child protection authority. Other aspects of power in this sense were manifest in the physical and interpersonal environment in which the disclosure interview took place. One adult had experienced abuse in a school setting and was subsequently interviewed by social workers in a children's playroom. Another was met by social workers in a hotel lobby, having to lower their voice in fear that members of the public might overhear. Participants also referred to their experiences following disclosure, once they had provided their information to social work services. A number of metaphors were used across the sample to describe this experience. Some referred to making a disclosure and then the matter "going into a void", "a black hole", or like "falling off a cliff". This echoes the findings of delay and lack of communication highlighted in many reports by the Health Information and Quality Authority and others (Office of the Ombudsman, 2017; Health Information and Quality Authority, 2017). Participants highlighted the good nature and sensitivity of some of the social workers. However, broader issues regarding belief, trust, control and powerlessness, which are significant features of the process of disclosure of childhood abuse, were often not fully appreciated and accounted for in practice. This again highlighted the persistence of a sense of 'personal sensitivity but professional helplessness' (Mooney, 2014: 10).

Thirdly, a theme was identified in respect of how the system could act as a facilitator. While the predominant experience of disclosure across the sample was negative, the participants did share views on what they wished would have happened or in some cases what they expected might have happened when disclosing to social work services.

Patrick suggested that *"a bit of clear communication could have sorted a lot out and I could have been kept informed"* He went on to add that *"…these are the important things, clarity, keeping someone up to date, even if it's fairly banal say this is what I can tell you this is what you're getting and this is where we are today, ahm… especially when you ask for it…"*. Another participant, Tony, stated that *"It's needs to be a statutory thing, I'm not, ya know there should be a standard protocol if someone makes a report"*. While Jane stated that *"even a little …sketch on the back of a napkin would have helped…"*. One of Alan's concerns was that he didn't know what the interview environment would be like, *"… I didn't get anything about how many people would be there I was, when I was travelling up in the car I was thinking, I don't know. How many people am I walking in to here?"*

Using the metaphor of the void, or black hole mentioned above, Patrick spoke of his experience following disclosure and the uncertainty he felt having made allegations against his family members, *"…no one actually wrote to me and said the letters have gone out, I was told they were going to send me a letter saying [the letters] have actually gone out today…"*. He gives an example of how this void can affect someone: *"…that void is going to be filled with something… and usually the imagination of somebody who has been sexually abused isn't necessarily the … straightforward imagination. It's probably going to be more paranoid, more ahm shame and guilt …and all those sorts of things and ahm… they [social workers] must know this, some of them have to have read a book on this somewhere, they must get it even vaguely intellectually if not from a lived experience or not from having worked closely with people to go 'this is important'"*.

Overall participants called for clarity, communication and understanding of what the possible effects of abuse in childhood may be, in particular the aspects of the interpersonal and physical environment. Understanding trauma, the person-in-environment and issues of power and control are central components to trauma-informed care (Wilson, Pence and Conradi, 2013). Wilson et al. state that at the heart of trauma-informed practice lies the question 'if professionals were to pause and consider the role trauma and lingering traumatic stress plays in the lives of the specific client population served by an individual, professional, organization, or an entire system, how would they behave differently?' (2013: 2).

One Possible Solution: the EU Victims Directive

Given what the research says about what the adults had expected or hoped for when engaging with child protection, it is important to explore various approaches that may facilitate and support disclosure. In the wider research project, consideration was given to further social work training in the area of sexual abuse and disclosure, an examination of the Barnahus model (see www.childrenatrisk.eu) and its possible use for adults (Bredal and Stefansen, 2017), and also a consideration of the role of social work in the assessment of retrospective disclosures in general.

Another important development, now discussed, is the *EU Victims Directive* (Directive 2012/29/EU), hereinafter 'the Directive'. The Directive became law in 2012 with an aim to ensure that "Member States shall ensure that victims are recognised and treated in a respectful, sensitive, tailored, professional and non-discriminatory manner, in all contacts with victim support or restorative justice services or a competent authority, operating within the context of criminal proceedings" (Article 1.1). It is split into a number of descriptive sections, explaining the origin and ethos of the Directive, followed by the binding Articles of the Directive. The Directive specifically recognises victims of sexual crimes in the context of gender-based violence (Section 17) and violence within the context of close relationships (Section 18). The Directive is victim-focused and aims to support victims irrespective of whether or not an 'offender is identified, apprehended, prosecuted or convicted and regardless of the familial relationship between them' (Section 19). Under the Directive a 'victim' is defined as "a natural person who has suffered harm, including physical, mental or emotional harm or economic loss which was directly caused by a criminal offence" (Article 2.1(a)(i)). This, therefore, in an Irish context, would encompass those who retrospectively disclose childhood sexual abuse to social work services; as such an assault constitutes both a crime and child protection issue simultaneously.

As stated above, disclosure of childhood sexual abuse is often an insurmountable task with individuals experiencing barriers from within, barriers in relation to others, and barriers in relation to their social world (Collin-Vézina et al., 2015). The Directive acknowledges and allows for the possible barriers to disclosure stating that '…the delayed reporting… due to fear…humiliation or stigmatization should not result in refusing acknowledgement of the victim's complaint' (Section 25). The Directive reserves special protection for children and those impacted by sexual crimes and addresses much of the issues that have arisen in the findings of this research. It sets out substantive sections on the Provision of Information and Support which includes a 'right to understand and be understood' (Article 3), a 'right to receive information from the first contact with a competent authority' (Article 4), including 'information about your case' (Article 6), 'right to access victim support services' (Article 8) and a minimum standard of such provision (Article 9). The Directive also includes rights to protection against repeat victimisation (Article 18) which will take account of the specific needs of the individual with specific regard to experiences of sexual violence (Article 22).

In terms of supports being offered to someone coming forward, Section 37 states that 'support should be available from the moment the competent authorities are aware of the victim…”. Such supports are detailed under Article 8 of the Directive and include a free of charge, referral to confidential victim support (8.1) facilitated by the competent authority (8.2). Such services should provide information, advice and support (9.1(a)), information about or direct referral to any specialist support services (9.1(b)), emotional and psychological supports (9.1(c)), and advice relating to the risk of secondary and repeat traumatisation (9.1e)).

While the Directive is framed in the context of criminal proceedings the drafting of the Directive is broad enough to encompass ancillary and related processes including child protection assessments carried out currently by Tusla (McDonald, 2018). In fact, the Directive comes in to play as soon as a complaint of an offence is made to a competent authority, whether or not a criminal investigation or process has commenced. This would therefore appear to encompass a disclosure of sexual abuse. The Directive is not prescriptive in respect of how it should be applied and in what setting. The Irish government has incorporated aspects of the Directive under the *Criminal Justice (Victims of Crime) Act 2018*. While such a move is to be welcomed, it is argued here that this fails to address crimes and abuses which fail to progress to the later stages of the criminal justice system and, in terms of sexual crimes and barriers to disclosure, this is arguable the majority. McDonald (2018), in her comprehensive review of the Directive, has emphasized that there is no valid why its provisions cannot be incorporated into other ancillary processes within the State. She goes as far as to specifically reference TUSLA as potentially constituting a competent authority under the Directive. In light of the various independent investigations and reports highlighting the complexity and failures in respect of retrospective disclosures it is worthwhile considering how some of the issues raised by the adults who participated in this study could be dealt with by incorporating aspects of the Directive into child protection practices.

Discussion

In recent years widescale public attention has been drawn to the issue of retrospective disclosures and social work’s management and assessment of same. This particularly came to prominence during the Disclosures Tribunal (Charleton, 2018) which, under its terms of reference, aimed ‘to investigate the creation, distribution and use by Tusla of a file containing false allegations of sexual abuse against Sergeant Maurice McCabe’. The allegation in this instance constituted a retrospective disclosure in that it was an allegation made by an adult of abuse that occurred in childhood. The negative findings of the Tribunal, in respect of Tusla’s management of this issue, led to the Minister for Children and Youth Affairs commissioning HIQA to launch a focused investigation regarding Tusla’s management and assessment of allegations of abuse. One of the recommendations from this HIQA process (Health Information and Quality Authority, 2018) was the establishment of the Departmental Expert Assurance Group whose work is ongoing at time of writing but who’s interim reports have highlighted much of the issues presented above and previously raised by the author (Mooney, 2014; 2018; Department of Children and Youth Affairs, 2019).

The complexities of retrospective disclosures, and the State's response are now prominent in public and policy discourses (HIQA, 2018; Department of Children and Youth Affairs, 2019; Office of the Ombudsman, 2017; Mooney, 2018). It is essential therefore, that the voices and experiences of adults coming forward to disclose, including those involuntarily engaging with the child protection system due to mandatory reporting, must be afforded equal, if not additional, attention. The participants of the study explained how they wanted to know what the process of disclosure to social work would entail, what would happen their stories, how would they be used, who would be told and when and, ultimately, what could be the outcome of such a process. While attention is now being paid to this area of social work practice it is argued that the system is still lacking in these core, victim-centred or trauma-informed, elements and practice remains inconsistent. There are examples of good practice in the Irish system, but the problem of 'variable and inconsistent' national responses have been highlighted as far back as 2008 and 2010, a decade ago (Office of the Ombudsman, 2010; Department of Health and Children, 2008).

The binding Articles of the *EU Victims Directive* cover a number of key issues and considerations, raised by the participants of this study, and could be viewed as fundamentally trauma-informed approaches to working with victims. The Articles which incorporate an understanding of trauma, the person-in-environment, the return of control to the adult and creation of safety (Wilson, Pence and Conradi, 2013) is important in this respect. Wilson et al. suggest that some of the key components of a trauma informed approach are physical and psychological safety, collaboration with and empowerment of clients and the need to identify trauma-related needs of clients (2013). Article 3 of the Directive promotes the right of victims to understand and be understood. It obliges Member States to take appropriate measures to ensure that communication with victims is accessible and takes account of the victim's individual circumstances. We can envisage how such an approach could address the seemingly basic lapses in communication raised by Patrick and others above. Provision of information relating to the process of social work assessment is therefore critical. This requires clear guidance and policy in the area which heretofore has been absent. In addition, many of the adults, having shared their stories and made formal allegations to child protection services, expressed concerns about who would be contacted, when they would be contacted and the possible effect this may have on them and their families. Patrick provided a vivid example of what it was like for him when he received little information following his disclosure, *"… 'cause you took the pin out of the grenade and you count to ten and … … … … (tapping table) months later, still going on, … and you know I still don't know where I stand"*.

Conclusion

Where our social work services receive disclosures relating to child sexual abuse that may, in some case, have occurred decades ago it is critical that practitioners consider the dynamics of abuse and disclosure over an individual's life course and ensure that such delay is not stigmatised. Disclosure should be viewed as a fluid and inter-relational phenomenon. Systems and practices that takes account of the such dynamics across the process of disclosure may be better suited to the needs of those coming forward and may go some way towards creating an environment that encourages, facilitates and supports disclosure of childhood sexual abuse.

It must be acknowledged that legal complexity and ambiguity, in the form of judicial reviews of child protection decisions and processes, can also breath defensive and risk-averse practice within social work (Mooney, 2018; Department of Children and Youth Affairs, 2019). It is therefore argued that not only could the EU Directive address some of the issues raised in the above-mentioned reports and in the findings of this research but it could go further to act as a template or starting point in the development of much needed statutory underpinning of the assessment of child abuse and neglect referrals, current or historic, by child protection services. Ultimately, this paper argues that some of the key concerns raised in a plethora of reports and by the experiences of those who participated in this research could be addressed by immediately implementing aspects of EU Victim's Directive into our child protection policies, practices and law.

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STABILITY FOR WHO? AN EXPLORATION OF THE EXPERIENCES OF PARENTS WHO HAVE CHILDREN IN FOSTER CARE.

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Abstract

Parents with children in foster care represent a group whose voices are seldom heard (Höjer, 2011). This paper focuses on the findings of a research project undertaken with parents who have experience of having a child(ren) in state care. Though a range of studies focus on the children and foster carer's role in 'stability in care' this research explores where the parent may be situated in this. Given the understanding that reunification is a key consideration within the child in care process, this study considers the concept of stability through the lens of parent's engagement and participation. In exploring factors that contribute to 'placement stability' research has shown that a positive connection to the 'birth family' is a powerful theme (Tobin, 2011). This paper focuses on the main factors found to influence stability (Moran et al, 2017) such as relationships, communication, support and continuity.

Keywords

Birth Parent's, Foster care, Communication, Experience of Services, Stability, Service User Involvement, Stigma, Shame, Child Protection.

Introduction

This practice-based research stemmed from both of the author's experiences of working with parents' who have or had previous experience of having a child in care. For the purposes of this paper, the term parent refers to 'birth parents'. This article highlights the voices of seven individual parents in relation to their experiences of 'stability' through their engagement with foster carers, focusing on relationships, communication and their perspectives on the current childcare system. A focus group occurred with three participants', followed by four separate qualitative interviews. The study was granted ethical approval through the authors' place of work (LSSC). All participants were already engaged with a supportive service and the study followed the Helsinki Declaration Guidelines, obtained informed consent and followed the study's rigorous distress protocol. This paper discusses the experiences of parents which were explored through an ecological framework (Bronfenbrenner, 2009). The primary research questions are:

- What are parent's experiences regarding factors that contribute to stability?
- What are parent's perspectives on their previous communication with foster carers?
- What are the factors that contribute to positive engagement between parents and foster carers and social workers?
- Based on parent's experience, how does the care system impact on parental participation?

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Introduction

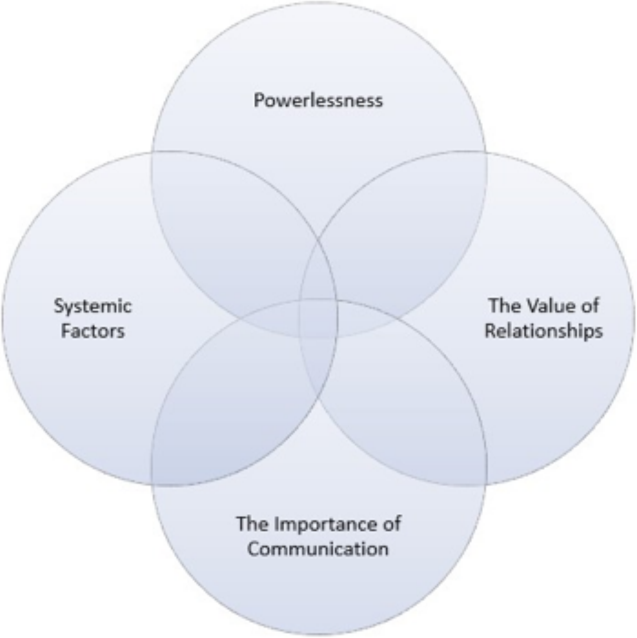
Stability in Foster Care

Stability in foster care can relate to children's feelings, both of connection and belonging, which can be characterised by emotional attachments to adults and siblings (Schofield et al, 2012). Moran et al, (2017) assert that the main factors found to influence permanence and stability were relationships, communication, support and continuity. Interestingly, themes emerging from Moran et al's (2017) study showed that it is not only the connection between the child and the foster family or parent that matters, instead, the whole system surrounding the child must also be taken into account. In acknowledgement of the whole system surrounding the child (Moran et al, 2017), this study utilised an ecological framework (Bronfenbrenner, 2009) to explore the systemic factors that may contribute to stability.

While a range of studies focus on the children and foster carer's role, this research explores where the parent may be situated in this. In exploring factors that contribute to 'placement stability' research has shown that a positive connection to the 'birth family' is a powerful theme (Tobin, 2011). While a positive connection is noted, how is this achieved, promoted or experienced? Parents with children in foster care represent a group whose voices are seldom heard (Höjer, 2011), therefore, our aim was to explore parent's experiences and perspectives. The factors that lead to a child both being and feeling stable and secure in their foster home can be divided into 'internal' and 'external' factors' (Moran et al., 2016; Roarty et al, 2018:53-54).

Themes Emerging from this Research

The findings that are discussed in the paper relate to parent's lived experiences. The data obtained through the focus group and interviews was thematically analysed with four key areas arising. Parent's personal sense of powerlessness was evident, as was their experiences of the barriers in establishing relationships with those involved in their children's care. Communication, both in positive and challenging terms was discussed. In conclusion, parents' experiences of the systemic factors that promote or affect stability was highlighted. The interplay between these four key areas will be discussed further:



Powerlessness

The loss of a child through the care system has enormous psychological effects on parents and can lead to circumstances that Broadhurst and Mason (2017) describe as 'collateral consequences '. The stigma which arises from having children in care can intensify parent's underlying difficulties and this can often lead to crisis. As noted by O'Brien et al (2015:8), the 'anger, frustration and powerlessness of parents engaging with the care system can militate against meaningful contact'. Frustration, and the exasperation of underlying difficulties were evident in parent's experiences. Feelings of powerlessness were cited, with reference to feeling unsupported, alone, isolated and withdrawn from their communities due to stigmatisation. Previous research has asserted that parents felt that labels were unfairly levelled upon them by society as 'unfit' and 'bad parents' and they are 'powerless in determining their own futures' (Moran et al, 2017:56; Slettebo, 2011; Regan and Riddler, 2010).

This was also evident in our study where parents spoke of the stigma they faced in their local communities when a child/ren was removed from their care. One parent spoke of the stigma that she felt when she collected her child from school for their unsupervised contact:

"If you have permission to collect your child from the school, and everyone else is collecting theirs… it's like they're looking down at you. It's like everyone's talking about you and you can hear them all whispering. You're standing there, going oh my God they're all talking about me now and you can hear them, you can feel them looking at you… you can hear them nattering"

Many parents have to deal with the trauma and loss of a child on their own, particularly as they may be ostracised by family and friends due to the stigma and shame of losing custody of their child through court-ordered removal (Morris, 2018; Broadhurst and Mason, 2014). A parent spoke of the impact that key dates have on her:

"Birthdays and Christmas, you get too depressed, you are just left there, rotting alone, literally alone, inside yourself, going deeper and deeper and you're trying to find a way out and you're screaming for help".

This parent spoke of her way of coping with stigma in the community and her anger regarding having her children removed from her care:

"Over the years, you just block it out, you just learn. It's like you put on armor, where you can't get hurt. It's an invisible armor or a mask so when you meet people, you're totally protected inside and they can't hurt you, but you've got to learn how to put these on".
While the previous parent identified her ability to protect herself from the stigma associated with having a child removed from her care, this was not the case for many participants. Reflecting on the complexity of parental experiences, Schofield, et al. (2011: 75) comment that emotional reactions to a child going into foster care are 'powerful, diverse' and that 'often contradictory feelings arise from their experience of loss'. How these manifests can have further consequences for parents? Emotional over-reactions such as anger, irritability in meetings, contact or towards professionals can exasperate perceptions of parents' stability (National Child Traumatic Stress Network, 2018). Several parents spoke of feeling that they had to hide their true emotions as 'it may be used against them':

"When my baby was taken into care, they phoned the next day and when I asked how she was, the social worker said that she was very unsettled in the foster home during the night. I wanted to scream down the phone…. but I couldn't….it would have been used against me, so I just said okay, thanks".

Feelings of anger, guilt, and powerlessness were referenced by parents. This sense of powerlessness was also present in recent studies (Morris, 2018; Broadhurst and Mason, 2017; Regan et al, 2010). In a study focusing on mothers, Morris (2018) reported that those who have their children removed by the state are haunted by the shame of being judged to be a deeply flawed parent. The feeling of having to suppress intense emotions was highlighted by several parents and the distress that this caused was evident. One parent called for a recognition of the emotions being expressed as natural:

"Well I think the social workers need to understand and fair enough not doing it in front of your child, but like it's normal for parents to get thick, upset, angry, cross, cry. They are all-natural emotions to have and if you do that in front of the social workers, they can label you unstable, and say oh your behaviour is erratic, your behaviour is a concern. They are normal emotions. You come and take someone's child off them, am I supposed to turn around and say Jesus lads, thanks very much, you're after doing me a favour. I'm going to go out now and enjoy myself- No, I'm going to be upset, I'm going to cry, it's my child, it's my baby'.

The Value of Relationships

Establishing caring and supportive relationships with the foster family is considered a crucial need of children in care (Bell et al. 2015). Furthermore, where these relationships are in the child's best interests, children in foster care generally need continuity of the relationships with their birth family members (Mason 2008; Moran et al, 2016). The importance of forming and maintaining of appropriate relationships between parents and foster carers was highlighted, as was the benefits to all involved when this worked well.

Discussing their previous positive relationships with their children's foster carers, feelings of being included and a sense of being valued emerged in parent's narratives. The smallest gestures towards them were greatly cherished:

'I know it's not a lot to people but when you're a parent and you get a birthday card; it meant a lot. I was never forgotten for my birthday, never forgotten for Christmas, Mother's Day or Easter. (the foster carer) made me feel number one to my children so I've nothing but good to say about her'.

Another parent noted:

"I know they have to care for the children, but it's great when you get included …. even though it doesn't feel like you're actually included, like going on trips with them (laughs). It doesn't have to be that, it's the little things like the updates and small talk at meetings. Once you tell a mother about her child, she'll relax".

Mutual respect was fundamental as asserted by this parent:

"there's respect there, there's loyalty from one mother to another mother …. if you don't have respect for each other there's no point even in trying to make it work".

The challenges faced by parents included feeling that decisions were made without their input or being isolated in matters relating to their children. Several parents spoke of feeling disempowered even when they were included in events relating to their children:

"I used to go to my daughter's doctor's appointments when she'd be getting her injections. If she was upset at all, the foster carers would get up and take her away. They wouldn't even say did she want to go to me and like I'd find that hard because I'm her mother and she was sore. They never gave me that chance to soothe her or try and calm her".

The relationship with the allocated social worker was discussed, both in its challenges and benefits. A core theme referenced by parents was the feeling of having to navigate supports on their own:

"The best line that I heard that's used by social workers, is I'm not your social worker, I'm your child's social worker. I felt that I couldn't go and ask any one of them for help, and yet the child is taken from your care because you've done wrong. Yes, you admit you've done wrong, you're screaming for help, to get better so you can actually have your child home with you. They should actually be there and saying that we're here to support the family, but I don't feel like they're supporting the whole family".

Several parents reported having a positive relationship with their social worker and foster carer as highlighted by this parent who referenced the benefits of open communication:

"It was all about working together, making decisions together. No decisions were made behind my back, I was involved in everything. So that's what made it work for me when I felt that I was involved and included in every decision".

The Importance of Communication

Open communication between social workers, children and families was seen as having a positive impact on relationships. Parents highlighted the benefits of feeling listened to and involved in matters relating to their children as well as adequate notice of meetings and contact. This parent relayed:

"I felt that I was involved with my children so that's what made it work for me. Involved…I was included in every decision, in every aspect of my children's lives. I knew my kids were okay, even if they had got the dentist, I didn't have to wait to go to a case conference to find it all out". But it hasn't always been like that, I had to fight so hard to get myself included in my children's lives'.

Parents highlighted the importance of being informed and involved regarding their children's lives. Many parents reported that they did not receive enough information about their children and the distress that this caused was evident. This parent spoke of her baby's first Christmas and the distress that this caused her given that no services were available for contact:

"The foster carers wouldn't and there was no social worker willing to contact me on Christmas day and let me know what my child's first Christmas was like. That was the worst day, like, the day when he was taken off me was bad but Christmas day, my child's first Christmas, that was the worst of all. I know he didn't know what was going on like, but not to even receive a call, a picture or even an email of my child on Christmas morning opening his presents that I got him like….it was horrible'.

Systemic Factors

It is well known that the majority of families involved in child protection experience multiple chronic stressors, including poverty, marginality, family problems, housing instability and social isolation (Kojan, 2010). Relative deprivation involves greater social insecurity and a range of risks are associated with income poverty (Featherstone, 2016). Stressors associated with parenting in poverty, 'including a lack of access to appropriate support services, are likely to impact upon the quality of parenting and increase, but do not accurately predict, the probability of maltreatment' (Hyslop, et al, 2018:6; Harknett & Hartnett 2011). The psychosocial difficulties that parents experienced prior to having their child removed from their care were further compounded for many parent's. Following the removal of a child from their care, the sense of 'loneliness and isolation impacts severely on parent's mental health, their ability to cope with everyday routines and how they manage relationships with foster carers, children, and social workers' (Moran et al, 2017:57). This parent spoke of feeling alone in accessing supports:

"When they get foster carers, they get them help, give them a Link Worker, tell them about the Foster Carer's Association or whatever but when you're the parent, it feels as if they don't want to know you. You've to climb out of that bed, with a heart that is broken into 1,000 pieces and find help for yourself and try and look for it yourself".

Navigating services was referenced by parents to be a challenge and the pace of change was noted to be frustrating. A parent spoke of waiting for over five years for their contact to be increased despite remaining sober:

"It's been so hard because, it's their way or no way. I'm doing the same thing for five years. It's been a long time. I should at least deserve to be getting her for the full day. Everything they've asked me, I've done. This is some test. I'm clean and they're telling me how good I'm doing and this and that but it's no good telling me how good and then still give me two hours (contact) a month".

This parent spoke of their frustration regarding the weight given to parenting capacity assessments, despite making the changes that were required of them:

"All hope can be taken from a parent as fast as you blink your eyes. I think it's very unfair because when you've been through so much, going into treatment, coming out of treatment, linking with all these services, proving clean urines, and bang… a parent capacity assessment says you've been through too much trauma, to parent your children. It's just more trauma on top of trauma'.

Child protection is practiced in a context of uncertainty, risk and deep anxiety (O'Sullivan, 2018; Featherstone, 2016). Foster carer's and parent's relationships can be strained, given the varying perceptions regarding the best interests of children and the challenges in understanding each other's perspectives (Browne, 2002). Several parents spoke of the difficulty in forming and maintaining relationships with social workers and the challenge that meeting a newly allocated one and 're-telling your story' can have. One parent noted:

"You could have a social worker, then all of a sudden you'll get assigned a new one and at the start, they ask questions like 'how are you feeling', and I'm looking at her…what do you want me to feel? I'm broken inside but I'm smiling out through my teeth but thinking F… off and leave me alone; how am I feeling? You live in my shoes and have your children taken from you and then tell me how you're feeling inside…"

Social work turnover was frequently cited:

"I know she was working for the child but she took the time to actually tell me what needed to be done and supported me in getting into services, but they moved her on too quick and then they brought in another one. it's rare that you actually get a social worker that sits down and looks at where the parent needs to get and gives that extra support".

The sheer complexity of engaging with the wide range of professionals within the system was described as overwhelming by parents.

"… there was so much going on with so many different people and so many different meetings, everything going on and like you're going through the loss of your child being in care and it's so confusing to take it all in and actually be able to remember times, dates, meetings, who said what. There is so many different people involved, and they all have different roles. It's so hard to like take on all those different people, and you're just sitting in there then, and you're like… you kind of feel lost".

Conclusion

The research provides an insight into the experiences of parents who have had children in state care. The research process identifies the challenges faced by parents in navigating supports that are primarily focused on their child. Salient points are highlighted by parents in relation to the need to feel supported as part of a family. While child wellbeing is central, viewing the child as also being part of a family is evidenced in parent's narratives and provides much for us to reflect on. In exploring the factors that contribute to 'stability' from a parent's perspective, this study highlights the value that parents attach to being included and involved in matters pertaining to their children. As highlighted by Devaney et al, (2018) parents' value everyday expressions of support i.e. a friendly word, empathy, time. The latter speaks of the 'ordinary work' of building and maintaining relationships which takes extraordinary skill and ability (Devaney et al, 2018).

For a parent, having a child removed from one's care is a primal wound. The responses to such an event can further exasperate concerns regarding capacity. Reflecting on the role of the social worker in overseeing the child's welfare in a statutory capacity, this is a difficult context in which to build relationships with parents (Connolly et al, 2016; Regan et al, 2010). The parents that took part in this study were very open to the idea of positive engagement with the services who were involved in their child/rens lives. What is emerging from the voices of the parents heard within this study is, that where attention is paid to that 'ordinary work' of supporting communication and relationships between parents, foster carers and social workers, this pays dividends in terms of parents feeling respected, included, and therefore more open to participate in the care plan for their child/ren. Given the importance of positive connection to the birth family (Tobin, 2011), increased parental participation can only promote better outcomes for children in care.

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A QUALITATIVE STUDY OF THE PROFESSIONAL INTERFACES BETWEEN CHILD WELFARE AND PROTECTION SOCIAL WORKERS (CWPSW) AND GUARDIANS AD LITEM (GAL) IN THE REPUBLIC OF IRELAND

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Abstract

This article is based on a presentation made at The All Ireland Social Work Research Conference in June 2019. It focuses on the PhD study being conducted by the author, who previously worked as a team leader in child protection and welfare social work. It begins with a brief review of the literature before summarising the preliminary findings of the study. The article then describes the methodology used to compare and contrast the experiences of both sets of practitioners. Preliminary findings include important insights into the interaction between these two professional groups.

Review of Literature

The legal and policy contexts underpinning this work are the Child Care Act 1991 and the United Nations Convention on the Rights of the Child (UNCRC). The Child Care Act is the vehicle through which a Judge can appoint a Gal to represent the wishes of the child as well as an opinion on what the Gal believes to be in the best interests of this child. This is in circumstances where ‘it is necessary in the interests of the child and in the interests of justice to do so’ (Child Care Act 1991, Section 26). The UNCRC, introduced in 1989, includes two articles particularly relevant to the area of study being undertaken by the author. These include Article 3 which states that all actions concerning children should be undertaken with the best interests of those children in mind. Likewise, Article 12 is of particular relevance as it states that the voice of the child must be heard and given due weight.

Four key sources were identified for the literature review: peer reviewed journal articles; books; official and legal documents; and grey literature (Whittaker, 2009). The literature review highlighted the limited amount of research that has been conducted in this area. Five key themes relating to the research questions were identified through the literature review. The themes that emerged were as follows:

- The differences in the professional profiles of the two groups were significant.
- A sense of professional threat existed in the interactions of these two groups and this was notably experienced by the CWPSWs in their interactions with their Gal counterparts.
- There was an absence of regulation of the Gal service in an Irish context.
- The nature of the inter-agency working between these two groups was beset with challenges.
- In the Irish context the Gal service was being seen as a compensation for an over-burdened, under-resourced social work service.

The first theme considers the differences in the professional profiles of the two groups, particularly in terms of differences in experience between them. More often than not the CWPSW had significantly less experience in their profession then their Gal counterpart (Parkes et al, 2015). The literature suggests that this may lead to the CWPSW feeling relatively powerless in the context of court processes. Another factor that may contribute to this sense of difference are high rates of staff turnover with CWPSWs, as a result information is sometimes lost, and staff tend to spend less time allocated to their cases. The general result is a contrast in roles and capacity between the two groups (Burns, 2010; McKeigue and Beckett 2010) a finding confirmed in a study carried out in Northern Ireland (Weatherall and Duffy 2008; CAAB, 2009).

A second theme, that of ‘professional threat’ occurs when CWPSWs report being treated in the court room in an inferior manner to their Gal colleagues. Research suggests that this is partly the fault of the CWPSW professionals who can fail to adequately represent themselves in court (Dickens, 2007). This is compounded by the court’s tendency to call on ‘expert’ witnesses which can diminish the value allocated to the views of CWPSWs (Dickens’ 2007; Parkes et al 2015; NCO 2004).

Moving to the third theme the literature points to the fact that the Gal service in Ireland is relatively unregulated when compared to other jurisdictions. Although there are extensive efforts being made to change this situation by the current government, this will take some time. Meanwhile we have a circumstance where one of the groups, the CWPSWs are externally regulated by a state body (CORU) whereas some GALs, who are not social workers, may not be so regulated. Another anomaly is the fact that the Gal is an independent service yet financed by the Child and Family Agency which creates a complex issue of governance and divergent responsibilities between the two groups (Mc Quillan et al, 2004; Parkes et al 2015).

The fourth theme refers to issues of inter-agency working between the groups.

The literature would suggest that, whilst professional distance is important to maintain independence, good co-operative working relations are necessary to ensure better outcomes (Jeffrey & Lloyd, 1997; O'Kane 2006). Philips (2016), in a US study goes further to identify specifically what makes for good working relations between these two professions and suggests a number of attributes for professionals, in terms of the individuals' personalities and willingness to engage as well as their capacity for good communication.

Finally, a fifth theme was identified by Martin et al in 2011 and Corrigan in 2015. Corrigan in her Irish study of the Gal service suggested that it appears to be compensating for an overburdened and under resourced social work service. This issue only serves to compound the sense of professional threat discussed in the second theme as well as diminish any progress that is being made in terms of good inter-agency working as mentioned in theme four.

Methodology

The review of literature described above informed the methodology used in the research, a qualitative study of the interfaces of Guardians ad litem (Gals) and Child Welfare and Protection Social Workers (CWPSWs) in the Republic of Ireland.

The research seeks to address the following research questions:

- What is the nature of the relationship between Gals and CWPSWs?
- How does the interaction between the professionals affect their work, if at all?
- What impact does the nature of their interaction have, if any on their client group of children and families?

A qualitative approach was used to elicit the views, attitudes and lived experiences of the participants (Flick, 2014; Whittaker, 2009). The research involves ten semi-structured interviews with members of each profession with another arm of the study using an observational approach to capture forms of decision-making in the courtroom. This extra dimension to the study will serve to triangulate the data as well as identify any issues that have not emerged in the course of the interviews. The issue of insider status is important to recognise, given the biography of the researcher as a former of child protection and welfare social worker. Full ethical approval was granted from Tusla for the purposes of interviewing their staff members, and from the Minister for Children and Youth Affairs for court room observation and UCD ethical approval for interviewing Gals.

Preliminary Findings

The findings now reported are drawn from an analysis of just over half of the interviews carried out, including two days observation, in camera, in the Dublin district children's court. They are ordered in the following, tentative themes: differences in professional profiles; sense of professional threat; interagency collaboration; lack of regulation and the Gal service as a compensation for an over-burdened social work service.

Differences in professional profiles
Initial data analysis suggests that there

is indeed agreement with the theme that highlights the significant differences in professional profiles. The CWPSW participants reported an awareness of the differences in professional experience amongst the two professions.

Professional threat
Likewise, there are strong opinions emerging in relation to the sense of professional threat being experienced by CWPSWs in the court room.

Interagency collaboration
There is significant variety emerging in the opinions of the two groups in relation to how well the inter-agency collaboration is working. This theme will need significant further analysis.

Regulation
There is no denying that there is an absence of regulation of the Gal service. To date the participants, have different views about the efforts to regulate the service. However ultimately it is, as of yet, unclear if the regulation will in fact impact on the nature of the relationship between the two professional groups.

The Gal service as a compensation for an overburdened social work service
Undoubtedly the fifth theme – the idea that the Gal service is a compensation for an overburdened social work service - raises divergent opinions amongst the interviewees. The spectrum of responses ranges from absolute agreement to absolute disagreement with this assertion. Over the course of the ensuing interviews and the analysis of the data this theme will be further analysed to develop a greater understanding of the responses.

Conclusion

The literature review has identified the themes that are prevalent between these two professional groups. The fieldwork to date is beginning to present data on how these themes are relevant to the Irish context. Over the course of the research, the author will engage in significant further analysis of these themes to fully understand the nature of the relationship between these two professional groups and the impact this may have on the client group they serve.

Limitations of the Study

This is a qualitative study that is designed to explore how practitioners understand their respective services, roles and behaviours and is not generalizable to the greater population of CWPSWs and Gals. The voice of the child is not being captured in this study and this can be seen as a limitation given the interface of these two professions is likely to have a direct impact on the outcomes and experiences for a child in these legal proceedings.

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EXPLORING THE ROLE OF SOCIAL MEDIA AND TECHNOLOGY IN INTERCOUNTRY ADOPTION REUNIONS: CONSIDERATIONS FOR SOCIAL WORK PRACTICE

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Abstract

This article, drawn from a larger study of the reunion experiences of intercountry adoptees focuses on the role of social media and technology in adoption reunion. This is the first Irish study to explore reunion experiences in intercountry adoption. The qualitative data was gathered through in-depth interviews with eleven Irish people who are adopted from outside of Ireland. The findings demonstrate that social media and other technologies are now a central feature of reunion in intercountry adoption and have contributed to a completely changed landscape of reunion. Social media and technology appear to have normalised and casualised contact with birth family; requires a level of digital literacy; and can add extra complexity to managing contact and boundaries. Participants report that while social media has facilitated their contact with birth family, it cannot and does not replace the need for ‘real life’, in person contact. However, it helped to prepare participants for the initial in-person contact and acts as a substitute for in-person contact between meetings. The implications of these findings for social work practice are considered.

Keywords

Intercountry Adoption; Search and Reunion; Post-adoption contact; International Adoption; Social Media; Communication Technology

Introduction

Social media and technology now play a central role in negotiating relationships and in connecting with people (Caughlin and Sharabi, 2013). Adopted teenagers and young adults have grown up with social media and technology in a way that was unimaginable at the time of their adoption (Fursland, 2013; Fursland, 2010). This article details initial findings of research exploring the role and impact of new technologies and social media on reunion experiences of intercountry adoptees in Ireland. This is drawn from a larger Irish doctoral study of reunion experiences in intercountry adoption (ICA). Between 1991 and 2018, 5510 ICAs have been registered in Ireland (AAI, 2019; AAI, 2013; Adoption Board, 2003). This study demonstrates a trend in using social media and other online platforms for both initiating and maintaining birth family contact, which has contributed to a completely changed landscape of reunion in ICA.

The impact and role of social media and technology on the experience of adoption reunion for intercountry adoptees has not been explored in adoption research to date. Black et al. (2016) and Greenhow et al's (2015) research on social media and adoption focuses on how parents manage and support their adopted children in relation to social media, boundaries and contact. Both studies highlighted the need for practitioners to have knowledge and understanding of the impact of social media and technology on post adoption relationships in order to support adoptive families. Fursland (2013), Pavao (2010) and Siegel (2012) draw attention to the issues and provide guidelines for adoptive families in managing social media. Haralambie (2013) explores the potential ramifications for the use of social media in post adoption search and reunion. The discourse in literature regarding social media and technology and adoption is frequently one of risk, however, the findings of this study also indicate the opportunities that social media and technology bring to post-adoption contact and reunion. O'Brien (2013) explored the impact of social media on adoption leading her to conclude that that the need for research in this area was 'compelling'. A recent review of adoption policy in Ireland suggested that adoption services are 'out of step' with the reality of social media. This review also highlighted the lack of state support for post adoption contact in ICA (DYCA, 2019). It is hoped that the current study will contribute to literature and social work practice by exploring how social media and technology shapes the reunion experiences in ICA.

Methodology

The study which this article is drawn from uses an interpretivist approach to focus on the reunion experiences of Intercountry Adoptees. Qualitative data was gathered through in-depth semi-structured interviews with a purposive sample[2] of eleven Irish intercountry adoptees aged between nineteen and thirty years and adopted from a variety of birth countries (see table 1). Due to the complexities of contact in ICA and the aforementioned changes in the way people communicate a broad definition of reunion that includes one-off meetings and contact facilitated by social media and technology is used in this study. Interviews were recorded digitally, transcribed and uploaded to Nvivo for thematic analysis (Braun and Clarke, 2006). Ethical approval was granted by the Social Research Ethics Committee, University College Cork.

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[2] One participant was recruited via non-purposive sampling to a university email list

Profile of Research Participants					
Participants	Gender	Country adopted from	Contact with sibling(s)	Contact with birth mother	Contact with birth father
Participant 1	F	Belarus	No	Yes	No
Participant 2	F	Columbia	Yes	Yes	No
Participant 3	M	Romania	Yes	No	Yes
Participant 4	M	Romania	Yes	Yes	Yes
Participant 5	F	Romania	Yes	Yes	No
Participant 6	M	Romania	Yes	No	Yes
Participant 7	M	Romania	Yes	No	No
Participant 8	F	Russia	Yes	No	No
Participant 9	M	Russia	Yes	No	No
Participant 10	F	Russia	Yes	Yes	No
Participant 11	F	Vietnam	Yes	Yes	Yes

Age and pseudonyms assigned to participants in the findings section are not included here for anonymity purposes.

Role of Social Media and Technology in Reunion in Intercountry Adoption

The findings reported here focus on the overarching theme of participants' experiences of using social media and technology in reunion and contact with birth family members. The six subthemes, which were identified using thematic analysis, are discussed here.

Role of Social Media and Technology in Search and Contact

Nine participants used social media and technology to facilitate their contact with birth family members. Two participants did not use social media or technology to communicate with their birth family, opting for traditional methods of letters, phone and in person contact. Of those participants that are using social media and technology to maintain contact with their birth family, nine are in contact with siblings and six are in contact with birthparents. The platforms participants used for searching and contact are social media platforms (Facebook and Vkontacte[3]) and video and messaging platforms (Skype, FaceTime, Facebook messenger and WhatsApp). The accounts of participants in this study corroborates earlier literature which suggests that searching and contact with birth family is now more likely to occur using technologically mediated communications than traditional methods of communication (Greenhow et al., 2015; Black et al., 2016; O'Brien, 2013; Fursland, 2013; Haralambie, 2013).

So we Skyped for the first night and oh sure Jesus my mam and my second oldest sister and my auntie, the three of them, they were waiting for me to answer the Skype call and I

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[3] A Russian social media platform

said, Jesus I was so nervous. (Abby)

Abby's experience of 'meeting' multiple members of her birth family for the first time via skype, suggests that reunion in intercountry adoption is very different from previous practice in domestic adoption where a first meeting has usually been between a birth parent and adoptee. Both parties would prepare and communicate initially through a social worker or other third party and safeguards regarding confidentiality and privacy would be in place to protect both the adoptee and their birth family (Fursland, 2010). This study suggests that a key difference in birth family contact via social media and other technology versus more traditional methods of telephone, letter writing and in person contact, is that contact is happening very quickly and people are getting in contact with multiple birth family members at the same time.

Normalisation of Contact

A 'normalisation' of contact seems to be occurring for participants in this study as a result of social media and technology. Participants describe exchanging pictures and videos using messaging apps and using video platforms to see and use body language to interact with birth family despite not being able to communicate verbally. This normalisation is demonstrated by this participant's contact with his birth family while on holiday:

… we rented it a car, a supercar, and we went out on the autobahn and I rang (facetimed) her out on the road, that was the last time I talked to her properly that was only a few weeks ago. (Frankie)

This resonates with experiences of migrant families who are using visual communication to create 'mobile intimacy' and build and maintain 'normal' relationships (King-O'Riain, 2015; Francisco, 2015; Cabalquinto, 2017). The important role that visual communication plays in the normalisation of contact in this study is described by participants including Laura, who waves at her birth parents on Face Time when they pop into the calls with her siblings. For Laura, who like most of the participants in this study does not share a language with her birth parents, the use of FaceTime allows her to communicate with her birth parents (albeit in a limited way) and create moments of intimacy.

Conversely, some participants would like more contact, the contact does not feel 'normal' and the ability to see that a birth family member is online and not communicating can cause upset and distress:

I'd love it to be normal like, I'd love like to be able to ring my mam and I'd say, morning mam, how are you? I hope you have a lovely day. To be normal. Not this thing of looking is she online and she won't even write you a message like you know, I just find it so strange like, it's very strange, you know look maybe that's her mindset. I don't know. (Emma)

Digital Literacy

Participants described moving between platforms as they become more useful for their needs over time and describe switching between translation platforms (e.g. google translate) and messaging and video calling platforms. A significant amount of digital literacy is required to switch and move between platforms in this way:

…like the language barrier so we always just talk through Facebook (messenger) or WhatsApp. I'd be lost without Google Translate… Then like obviously sending photos, videos, like they've been showing me their town, their area and stuff and like I've been doing the same for them. So, like even kind of being able to show each other the two different worlds and stuff like. It's just mad like. They are the other side of the world. (Margaret)

Like migrant families, intercountry adoption dyads must engage in digital mobility, the ability to be together using technology and mobile devices if they want to have contact (Urry, 2007). In order to engage in digital mobility, network capital is required. In this research, age appeared to be the main barrier for people engaging in digital mobility. Birth parents seemed to be impeded by the technology and in most cases their communication was mediated by their children, the participants birth siblings. This finding is similar to Cabalquinto (2017) study of migrant families where age was the main factor that caused unequal ability to engage in mobile intimacy and older participants usually asked for younger family members to help them to use the platforms. However, unlike the participants in this study, migrants' families usually share a language and this study suggests that the lack of a shared language may be posing an additional barrier to developing mobile intimacies.

Managing Boundaries

Boundary management is a frequent theme in adoption research (for example Black et al., 2016; Goldberg et al., 2011; March, 2015; MacDonald and McSherry, 2011; Brodzinsky and Goldberg, 2016) and was also identified as a theme in this study. For some participants the frequency and ease of access facilitated by social media and technology can leave participants feeling obliged to be in contact or feeling guilty for not interacting:

They write on my timeline quite a bit and then they tag me in stuff, but I'm very bad with checking Facebook and like, because I'm too lazy to reply. So I don't reply as much as they probably want me to, but I do like, I like their posts and stuff. (Laura)

While Laura does not always reply to her siblings Facebook posts, she manages this by using the 'like' feature in Facebook which shows that she is 'listening' and seeing their posts. Emma's strategy for managing the contact on social media was to set up a separate Facebook account which she uses exclusively for birth family. Frankie has been in contact with his birth aunt for a number of years but has just recently felt ready to connect on Facebook:

I've finally given that leap in the last year to let her have my Facebook account and then she sees all, she's like, she's funny, she's liking everything like back to the first day ever so she's obviously done a good old search (Frankie).

Participants in this study experienced breaches of boundaries and these mainly occurred in a social media context.
Social media and technology comes with complications regarding boundaries and the rules of interaction are not yet fully established (Bryant and Marmo, 2012). Social media allows birth family to communicate in a very public way by liking and commenting on pages. Participants describe mixed feelings around this type of public contact. Laura has also had the experience of friends of

her birth family getting in touch with her over Facebook and she manages this by not accepting their friend requests. Participants are demonstrating ongoing vigilance in terms of managing boundaries when using social media and technology to stay in contact with birth family. They are constantly negotiating what feels right and comfortable for them and their birth family and this appears to evolve and change.

Online vs Face to Face

Eight of the participants have met birth family members in person and they are very definite that virtual contact does not compare to meeting in real life. Meeting in person was a very surreal experience and the importance of touch and the opportunity to do everyday things with birth family was emphasised by participants:

…the only way you actually can say that it's true is by touching the person like physically grabbing their arm or their hand and just figuring out are they, is this real or not. (Frankie)

…just to spend time with them, come on let's go to the shop or come on let's go for a coffee or something to eat, you know it was the social media all things that I really loved you know. (Abby)

Virtual contact seems to act as a safe place for adoptees to develop and explore their relationship with their birth families before meeting face-to-face:

…it helps a great lot, messaging each other forward and back and literally just seeing each other on Skype, on video, on Facebook on you know only for that you wouldn't have anything like…it was a great help…you kind of knew what you were preparing for (Abby)

Participants (n=3) who have not met their birth family in person, are clear that virtual contact is limited, and it will be important to meet.

…not talking to them, because of the language barrier, but just be able to like hang out with them and get to know them better, what they're like and stuff, because there's only so much you can do over text message…to be able to hug them and stuff would be great. Yeah. Give them a bit of a high five sometimes. (Laura)

Laura captures the sentiments of participants which indicates that despite the advances in communication technologies which allow people to be together visually and audibly in the moment, it does not remove the feeling of needing and wanting physical togetherness. This corroborates with migration literature, which suggests that online contact does not necessarily compensate for physical proximity and intimacy and can further emphasise the distance between participants (King-O'Riain, 2015; Cabalquinto, 2017; Cuban, 2017). Sam likens the contact with his siblings to contact with someone on an online dating platform and feels that until they meet in person they cannot develop a bond or take the relationship forward. For participants in this study, where sharing news and emotions was constrained due to language, being physically together seems to be particularly important.

Engagement with Online Support

A small number of participants (n=3) are members of online support groups and just one, Margaret, is an active member:

I don't know how many groups I'm a part of but yeah no it's great. Because they are *all obviously adoptees, it was nice. Kind of being in that community of people like that understood you know some of the feelings or the triggers that you may have, and you didn't feel like, oh like I thought I was the only one. Oh my God there is a whole world of us out there. (Margaret)*

Margaret has found it very helpful to access other people through social media groups who are in a similar situation to her. Some Participants (n=4) have also told their story online through blogging, making documentaries or YouTube videos. Initially, Margaret started her blog to help to publicise her search and it was shared widely by over 30,000 people. This helped her to find her birth family. An unintended consequence of this was the support and well wishes she has received through her blog. The small number of participants engaging in online support groups was surprising in this study, there has been limited research on this topic but a recent Australian study by Fronek and Briggs (2018) found that the majority of participants (8 of 11) were engaging in online adoption support groups and found it particularly helpful for practical and emotional support.

Considerations for Social Work Practice

1. Greenhow et al. (2015) suggests that where contact occurs in intercountry adoption using social media and technology, it is less likely that there will be professional support or guidance involved. Ten of the eleven participants in this study are not accessing any post adoption support. While not everyone who has contact with birth family will need or want to engage with social work support, the limited availability of post adoption support for adult intercountry adoptees in Ireland may also have an impact on this. Given the complexities of contact in ICA, there is arguably a role for social work in supporting adult adoptees in navigating these relationships.

2. The findings point to the complexities and 'new' challenges of navigating relationships and managing boundaries when using social media and technology. Adoption social work services will need to take this into account in training and assessment of adoptive parents and post adoption services in both domestic and intercountry adoption services.

3. The importance of face-to-face contact has been highlighted by this study. It is clear that technology supports and prepares people for this contact but without exception, participants referenced the importance of meeting in-person. This is important to consider where many intercountry adoptions continue to be closed adoptions with little information available and limited possibilities for contact due to factors specific to ICA including distance, culture, language, cost and digital infrastructure.

4. The lack of a shared language and differing levels of network capital seems to be impacting on participant's ability to build relationships with birth family. This suggests a possible role for professional support in terms of managing the relationship and access to professional translation supports. This also emphasises the importance of adopted children learning the language of their birth country.

5. Birth families in this study did not

have any formal support. A number of participants who met their birth families in person used translators or legal professionals and where this was the case some support seemed to be provided for birth families by these professionals. This suggests a role for the international social work profession in supporting birth family members in the birth country.

Conclusion

This study is the first empirical research that has focused on the role of social media and technology in reunion for adult intercountry adoptees. It brings forward earlier research on the role of social media and technology in adoption contact and reunion by Greenhow et al. (2015); Black et al. (2016) by focusing specifically on the experiences of intercountry adoptees. Participants described mainly positive feelings regarding their use of social media and technology in facilitating contact and developing relationships with birth family. However, along with the ease of access and opportunities for connection that social media and technology provides, some associated challenges are also identified. While social media and technology allowed participants to normalise contact with birth family, it also requires a level of digital literacy and access to technology which members of birth family and particularly birth parents did not always have. Other challenges related to managing boundaries and the pace, frequency and type of contact. While social media and technology is facilitating contact; relationships and moments of intimacy with birth family, all participants were clear that it did not replace the need for physical proximity and togetherness. It is hoped that this research will be beneficial to adoptees who embark on searching for and making contact with birth family; adoptive families; and adoption social workers and professionals.

In 2013, O'Brien suggested that the pace of change in this is area is so fast that research, practice and legislation has not yet caught up. In 2019 this continues to be the case. A recently published audit of Irish adoption research found limited research on search and reunion and in relation to people who are adopted from abroad (O'Brien and Mitra, 2018). Social networking and technology have not been addressed in recent adoption legislation and anecdotally practice continues to grapple with the issues and challenges involved. This study indicates a need to build a professional knowledge base on the role of social media and technology in reunion in ICA as a search tool, a communication platform and a support network and it is hoped that this paper contributes to this.

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RECOVERY AND CO-PRODUCTION: UNDERSTANDING THE DIVERGING PARADIGMS AND POTENTIAL IMPLICATIONS FOR SOCIAL WORKERS

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Abstract

The concept of recovery is well documented in Irish Mental Health discourse and policy in 2018. There have been 3 recent publications from the Advancing Recovery Ireland initiative, which has outlined how services can become more recovery orientated, focusing on several key themes; co-production, recovery education and family recovery. These are key documents for supporting services in becoming more recovery orientated. In order to attain a greater understanding of recovery and co-production in mental health services, the author carried out a systematic approach to the literature review, focusing on several key databases. There were a number of key findings in relation to recovery and co-production, including how the concepts diverge, the challenges faced in its implementation in practice, and the significant role that could be adopted by mental health social workers in relation to the shift towards personal and social recovery in mental health policy and practice.

Abstract

The concept of recovery is well documented in Irish Mental Health discourse and policy in 2018. There have been 3 recent publications from the Advancing Recovery Ireland initiative, which has outlined how services can become more recovery orientated, focusing on several key themes; co-production, recovery education and family recovery. These are key documents for supporting services in becoming more recovery orientated. In order to attain a greater understanding of recovery and co-production in mental health services, the author carried out a systematic approach to the literature review, focusing on several key databases. There were a number of key findings in relation to recovery and co-production, including how the concepts diverge, the challenges faced in its implementation in practice, and the significant role that could be adopted by mental health social workers in relation to the shift towards personal and social recovery in mental health policy and practice.

Keywords

Mental Health, Co-Production, Recovery, Recovery Colleges, Social Work, Service Users, Family/Carers.

Introduction

The concept of recovery for many years has been viewed as a vague and misunderstood concept. In recent years, it is widely accepted that recovery is a very personalised journey, and that co-production provides an approach which is inclusive of service users, family/carers, professionals and any other stakeholders fundamental to the process. Advancing Recovery Ireland have published 3 documents in 2018 which are to be utilised by mental health services to inform and enable their implementation of recovery-orientated services and interventions. The author of this research wanted to look at what mental health literature globally is saying about these key concepts with a view to the challenges facing Irish practitioners moving forward. Firstly, an overview of recovery and co-production are discussed, with a concluding section on how they can potentially work effectively together. The author then converses on the key themes associated with applying a co-production approach to understanding recovery in a mental health context. One key example is the introduction of recovery colleges in Ireland and internationally. Finally, there is a discussion regarding the significance moving forward in relation to social recovery and personalisation, with the possible implications for mental health social workers.

Methodology

The author adopted the systematic approach from the book, *Making Research Work, Promoting Child Care Policy and Practice (1998)*, adopted by Kathryn Higgins and John Pinkerton. This was supported by the search statements being constructed based on the format comprehensively explained by Kugley et al (2016) in chapter 5 of their publication, *Searching for Studies: A guide to information retrieval for Campbell Systematic Reviews.*

Higgins and Pinkertons approach takes into consideration traditional social science formats and science of systematic approaches. It maintains key elements of a narrative review but is underpinned by a systematic approach. It is a six-step model which assists the researcher in completing a literature review which is rigorous, methodical and systematic (Higgins & Pinkerton, 1998).

The author focused on three databases for this review following discussions with the subject librarian in Trinity College Dublin; PubMed, PsychINFO, Web of Science. The authors initial result from each database were quite high. However, these were greatly reduced by the subject filter being used. Following on from this, the researcher coded the articles from high priority to low. High priority articles included the concepts co-production, recovery, mental health and any key stakeholder; service user, mental health professional or policy maker. The author also adopted a manual approach to seeking other relevant articles from the bibliographies of the high priority articles retrieved. A number of generic social work books were also referred to.

Recovery

Service provision and policy in Ireland in recent years has been focused on how to implement recovery-oriented approaches into education and care settings (Casey & Webb, 2018). Social Workers are key members on multidisciplinary teams, and this shift in approach, has aligned more closely with their skills and knowledge (Mental Health Commission, 2006, Brosnan & Sapouna, 2015).

It has been well documented at this stage within mental health literature, that recovery-orientated practice is a dominant discourse. It is a key provision for mental health services globally (Ford, Bowyer & Morgan, 2015). Governmental policy and mental health services are focused on determining how best to measure recovery in practice. Countries are adopting different approaches to analyse this area of interest, with no general consensus internationally of how services can best measure their recovery orientated focus (Petrakis et al, 2014).

Two diverging paradigms; Recovery and Co-Production

Recovery oriented services and co-production can be viewed as "complimentary" within the mental health literature (Dalgarno & Oates, 2018, p.351). Again, the significance of empowerment and the lived experience of service users are key aspects of these approaches which fit seamlessly with the skills, values and knowledge base of social work (Brosnan & Sapouna, 2015, Brophy et al, 2015).

Co-production, just like personal recovery, is an approach which contests the historical relationship between mental health service users and professionals. In other words, the power imbalance which is well established. More recently, co-production has entered the realm of mental health discourse, and again, it is a concept which is being perceived as "excessively elastic" (Dalgarno & Oates, 2018:351).

Recovery as a concept has construed misunderstandings associated with it. It has been defined as a working misunderstanding (Pilgrim & McCranie, 2013). Just as recovery has been viewed as vague and misunderstood, co-production is also under scrutiny.

Co-Production

Co-production has become the new dominant theme permeating through mental health literature. It has become the new way of doing things, how policy and practice can finally intertwine, providing realistic, rather than idealistic outcomes for services on a global level (Ford, Bowyer & Morgan, 2015, Pinfold et al, 2015, Turner et al, 2015, Grey, 2016, Dalgarno & Oates, 2018, Pilgrim, 2018, Kirkegaard & Anderson, 2018). In terms of conducting research on the use of co-production in mental health services, there is limited data (Pinfold et al, 2015).

Historical, Philosophical and Epistemological Context
The term co-production originates from the 1970s, where it was a fundamental intervention used to accomplish equality between citizens and professionals during the civil rights and social action movements in America (Dalgarno, 2018). The interest in co-production internationally has grown significantly in recent

years, with it being adopted as an approach to be applied across the public services including social care and health (Turner et al, 2015).

Co-production challenges positivist epistemologies, and as a result adds to the debate regarding knowledge, and how it is produced (Pinfold et al, 2015, Kidd & Edwards, 2016). Co-production is about multiple perspectives, not just one. It is about shifting away from research being done on a topic which is naturally a passive process for the population being studied. Instead, the population under study are active agents in the process of (Kidd & Edwards, 2016).

It is underpinned by a philosophy to create knowledge which is socially inclusive. It aims to identify the dominant discourses within the political and social context, which allows for power imbalances to be addressed between service users and providers. Experience and expertise are key drivers within the co-production paradigm. People who have lived and experienced it, are the experts in their own right (Kidd & Edward, 2016). It is about providing an opportunity for all key stakeholders being experts by experience to make a contribution.

Challenges

i) Equality or Power Imbalance?

There is the potential for this shift in power to take place, but it can also "re-inscribe existing power relations" (Grey, 2016:248). Co-production can be easily adopted and interpreted as another service user participation initiative. A key difference between service user participation and co-production is the transformative element. Projects have good intentions whereby they have service users involved in an advisory capacity. For example, service users can act as advisories to improve the participant recruitment of a particular service. However, there role may not extend any further (Grey, 2016).

The risk with such intentions and actions is that mental health services and organisations can potentially end up replicating another false pretence. In other words, the well-intended approaches such as recovery and person-centred care have the potential to influence and transform the relationship between professionals and service users, but this does not necessarily take place in practice (Walsh et al, 2008, Grey, 2016). Instead, the predisposed power imbalance can be maintained.

ii) Marxism and consumerism

Co-production can be perceived as a branding agenda (Grey, 2016). The concepts of co-design and co-creation are conceptualised as marketing processes (Sanders & Stappers, 2008, Burkett, 2014). These are powerful tools being used to increase profits. These series of processes lead to increase market share and profits (Burkett, 2014).

Grey explains that this argument is perhaps too extremist, especially in relation to mental health services. However, there can be connections made, with one example in particular being evidenced from the mental health organisation 'Mind' in the U.K. In one of their key documents commissioned to look at co-production within mental health services, it is outlined in the foreword section that the research is aimed at positioning "the network of local minds as market leaders of high quality, recovery focused, personalised services, that individuals want to buy" (Slay & Stephens, 2013:2).

Grey goes further into documents being published by organisations such as Mind, concluding that co-production can be depicted as a form of unpaid participation from service users, families and the public in the evaluation and improvement of services (Grey, 2016).

iii) The role of the service user?

An article published, *Participation in Mental Healthcare: a qualitative meta-synthesis, identified that service user participation within co-production remains an aspiration* (Stomski & Morrison, 2017). The authors of this publication adopted a systematic approach to a literature review, which was a demonstration of meta-synthesis. Ultimately the findings questioned the impact of co-production on mental health services, especially in reference to the role of service users (Stomski & Morrison, 2017). This issue is discussed further by Jed Boardman in the *British Journal of Psychiatry* (2018).

Health services must be judged based on whether they actually assist those who use them. It is outlined that the routinised measurements being used currently do not focus sufficiently on the perspective of service users. Both service users and their family/carers need to be included at each stage of the "process of developing, testing and measuring outcomes" (Boardman, 2018:5).

Boardman argues that co-production is needed to facilitate this. He states that the research culture must shift from one which only places priority on professional expertise and evidence-based approaches. Instead, the environment must place equal value and appreciation on expertise through lived experience, and value-based approaches (Boardman, 2018). The need for increased service user participation further highlights the potential role that could be adopted by mental health social workers to achieve such aspirations (Brophy et al, 2015).

iv) Family and carers

Social workers are viewed as experts in the process of engaging and working with families in many social contexts (Trevithick, 2011, Campbell & Davidson, 2012, Francis, 2014, Payne, 2014). The role of family members/carers within models of recovery is emerging as imperative for achieving outcomes for people with mental illness (Bradley, 2015). The shift from institutionalisation to community-based approaches has been documented extensively both in Ireland, and internationally, since the latter stages of the twentieth century. In Ireland, a report from the Commission of Inquiry on Mental illness represented the first policy document to advocate for this shift in service delivery (Kelly, 2004).

This gained more emphasis in later documents, *The Psychiatric Services – Planning for the future* (1984), and most recently, A Vision for Change (2006). The transition to the community has happened to an extent, but the further it moves in this direction, the more family members become a fundamental agent in this structure (Bradley, 2015). As discussed in detail, Co-production offers this new approach, a way of potentially achieving these aims by involving family members in the delivery of services.

Recovery colleges: an example of using co-production to understand recovery

Recovery Colleges have been a significant development within a mental health context due to the ambiguity and a lack of clarity with how recovery is conceptualised and operationalised. As a result, service providers received recommendations to set up educational centres focused on recovery (Windsor et al, 2017, Dalgarno & Oates, 2018, Crowther et al, 2018).

These colleges aim to look at recovery through education, rather than treatment. They are underpinned by a co-production approach to understanding recovery. It is imperative that not only professionals, but service users are central to all discussions, actions, processes and outcomes (Dalgarno & Oates, 2018). Ultimately, they're focused on recovery education, and supporting this approach to mental illness through education (Crowther et al, 2018).

It has become a global innovation which was first established in Boston and Phoenix in the 1990s. It has since spread internationally, with it becoming more focused on co-production and co-learning. In 2017, there were 80 colleges in United Kingdom (Crowther et al, 2018). Furthermore, they are in the process of being setup, or currently running in another 22 countries. These include Ireland, Australia and Japan (Crowther et al, 2018). Ireland currently has 5 recovery colleges (Dublin North, North East Recovery College, 2018).

Generally, each recovery college course will have a facilitator with lived experience of mental illness. In some colleges, people with lived experience will be involved in "managing, developing, academic and evaluation committees" (Windsor et al, 2017:282). The role of co-production is a fundamental component to how recovery colleges function, and are carried out (Windsor et al, 2017).

Effectiveness?

The recovery colleges are viewed as a key component to educating and improving service delivery from a recovery-oriented perspective. In Britain in particular, there has been a rise in the level of research being gathered from recovery colleges, with one study in particular looking at the impact on professionals attending the colleges (Perkins et al, 2017).

This study used an online survey to gather both qualitative and quantitative data from 94 participants working in the NHS. The results of the study demonstrated that the recovery colleges were having an impact on influence professionals to be more recovery focused when returning to work (Perkins et al, 2017).

The literature on recovery colleges is continuously growing. People need to have more access to these services. The vast majority of people do not get the opportunity to attend such colleges, even though they provide an innovative approach to recovery and an understanding of how to be more orientated towards these principles (Windsor et al, 2017).

Social work, Social Recovery and Personalisation

i) Social Recovery

A key focus across mental health structures in countries worldwide has been a shift towards implementing the ideas associated surrounding not only recovery, but personal recovery (Anthony, 1993, Barker, 2003, Fisher, 2008, Pilgrim, 2008, Barker and Barker, 2011, Pilgrim & McCranie, 2013, Higgins & McGowan, 2014, Brosnan & Sapouna, 2015, Gaffey et al, 2016).

However, the focus on social recovery has not attracted the same coverage or analysis (Ramon, 2018). The concept of recovery has many meanings attached to it, with it referred to as “polyvalent concept” by one of the key writers on this subject, David Pilgrim (Pilgrim & McCranie, 2013:39). Although there is perhaps a clearer understanding of personal recovery at this juncture which is perceived as the journey taken by someone following their diagnosis. It is depicted as an individual journey taken by someone through changing their “attitudes, values, feelings, goals, skills and/or roles, to a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness” (Ramon, 2018:2).

Social recovery is interrelated, but it is distinctive in its own right. The focus is on people with mental illness interacting with others in their social world and the interdependence of their relationships. There are a number of key themes which are derived from this perspective including “connectedness, recovery capital and social capital, as well as the impact of collective culture and the structural elements of our socio-economic political system. These components must each be considered in relation to the identity of each individual, while also referring to how others perceive them (Ramon, 2018).

An alternative definition regarding the concept of personal recovery, depicts it as a person living with their symptoms, but also being able to live beyond them. This depiction of recovery focuses on moving past the symptoms and being an active member within a community. When people are asked what has impacted the most with regard to their recovery journey, it is the hope and belief they felt from others around them. Not only does this demonstrate evidence of interdependence, but it also epitomises “the relational aspect, the connectedness, the solidarity, and the importance of our social belonging” (Ramon, 2018:2).

ii) Personalisation

The recovery concept has been argued to have a number of similarities with the concept of “personalisation” (Turner et al, 2015:244). They both espouse a person having control of their life, and the journey they choose to take with active engagement in their community (Turner et al, 2015). A key factor underpinning personalisation is the significance of finding new ways of service users and professionals working collaboratively and actively engaging in the “design, delivery and evaluation of services (Social Care Institute for Excellence, 2012:2).

A personal recovery perspective is far more than just moving away from the medical model of care, but instead, improving people’s experience, ethically and socially. In order for a recovery orientated approach to be fully realised, there needs to be a focus on the social justice component which largely emanates from the conceptual framework of social recovery (Ford, Bowyer and Morgan, 2015).

iii) Social Work

The systematic approach taken to retrieving articles from the various databases used, provided only one article which focused on social work and its contribution to the area of recovery and co-production. This publication refers to the Australian context, but nonetheless, offers relevant implications for practitioners in Ireland (Brophy et al, 2015).

It is well known that the number of social workers within mental health services is far less than some of its allied health professionals such as nursing (Horgan et al, 2018). As noted, the complete lack of publications internationally, and more specifically in Ireland is concerning. This is especially significant because of where mental health policy and practice globally is shifting, with a focus on implementing recovery through co-production (Grey, 2016, Dalgarno & Oates, 2018, Pilgrim, 2018, Kirkegaard & Anderson, 2018).

Social recovery and personalisation have been discussed as increasingly significant concepts within the mental health literature. The landscape of mental health is placing centrality and emphasis on individualism, personalisation and consumer-directed approaches (Brophy, 2015). The concepts of recovery, social work and personalisation have all been discussed in positive association with one another in a number of articles (Carpenter, 2002, Davidson et al, 2010, Coyle, 2011, Lymbery, 2014, Brophy, 2015). The study carried out (Brophy et al, 2015:110) identified that service users "prioritised specific supports to improve their health and well-being, financial situation, social connection, housing and personal relationships".

There are barriers to achieving such aims. These include poverty, risk and the agency/structure conundrum debate (Clifton et al, 2013, Brophy 2015). However, although not taking away from the hugely valued role of other disciplines within a mental health context, social workers specialise in negotiation, advocacy and psychosocial assessments (Fawcett & Plath, 2014, Brosnan & Sapouna, 2015). Social workers are trained specifically on building relationships with people and placing the person at the centre of any intervention (Trevithick, 2011, Campbell & Davidson, 2012, Francis, 2014, Payne, 2014).

Conclusion

Co-production is viewed as the new way for services to understand and support an individual's recovery journey. This article focuses on a critical analysis of co-production, extrapolating the key themes underpinning the approach. It is an approach which promotes inclusivity of all key stakeholders, with service users and carers being viewed as experts in their own right regarding recovery. The literature identifies challenges to this approach. This encompasses potential power imbalances and market capitalism. Recovery colleges represent an example of co-production in practice, which the author discusses from a global perspective. Finally, the intersectionality of personalisation, social work and personal and social recovery is analysed, with the author stating that mental health social workers have a vital role to play in the transformation of policy aspirations globally, which is inclusive of Ireland.

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SUPPORTING CHILD RELATIVES OF ADULTS WITH ACQUIRED BRAIN INJURY: A RESOURCE FOR REHABILITATION TEAMS

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In 2018, she launched a resource entitled ‘Supporting Child Relatives of Adults with Acquired Brain Injury’ and has presented on the development of this pack at various conferences, including the All Ireland Social Work in Research Conference 2019, for which it received a high commendation.

Abstract

In the National Rehabilitation Hospital (NRH), the interdisciplinary team works with patients with acquired brain injury and helps them to achieve goals in order to improve their quality of life. While some consideration is given to child relatives, there has been an inconsistent approach in terms of helping children cope with and adjust to their brain injured parent or relative.

In order to help address this gap, the NRH social work department developed a resource pack, the aim of which is to strengthen the family approach to rehabilitation, and ensure children are integrated into the rehabilitation programme.

The resource pack has been designed to provide staff with the tools and confidence to work with children, based on literature focusing on the impact of acquired brain injury on child relatives (Daisley et al 2009, Kieffer-Kristensen et al 2013). It was launched in October 2018 and has been distributed to clinical staff in both Ireland and abroad. The purpose of this article is to describe the background to the development of the pack, the literature informing it, its contents, and plans for its future adaptation.

Keywords

Family focused rehabilitation, acquired brain injury, child relatives, social work research

Introduction

Acquired brain injury (ABI) refers to an injury to the brain which occurs following birth. It can be caused by a fall, a blow to the head, a road traffic accident, an aneurysm or a stroke. According to the International Brain Injury Association (www.internationalbrain.org), brain injury is the leading cause of death and disability worldwide; and traumatic brain injury

(TBI) is the leading cause of seizure disorders. After an ABI a person can experience many symptoms, including reduced mobility, impaired cognitive skills, or inability to speak or communicate. Research has shown that children with brain injured parents can have significantly more emotional and behavioural problems than children in the general population (Daisley and Webster, 2008). While some consideration is given to child relatives in the rehabilitation programme in the National Rehabilitation Hospital (NRH), the process has been largely client and carer centred. The relationships between injured persons and their children has not been a consistent focus for the Interdisciplinary Team (IDT) although there has been a new emphasis in recent years on the importance of family focused rehabilitation (Daisley et al 2016, Holloway & Tyrrell 2016, Kieffer-Kristensen et al 2013).

To address this gap, a resource pack was designed for all members of the Brain Injury IDT in the NRH with the aim of providing guidance and advice on working with child relatives and including them in the rehabilitation process, in keeping with best practice guidelines in international literature (see Daisley et al 2016, Holloway et al 2016 among others). It also offered guidance on how to assist the non-injured adult relatives to support child relatives and maintain key family relationships.

Suggestions and ideas on how to communicate information about ABI with children, the impact of loss and change linked with developmental stages, the importance of including parenting skills as part of goal setting and a list of useful tools and resources are also included.

The ‘Supporting Child Relatives of Adults with Acquired Brain Injury’ resource pack was launched in October 2018 and has since been accessed by rehabilitation agencies in Ireland and abroad. The purpose of this article is to discuss the process involved in developing the resource, explore some of the literature that informed it, provide a brief summary of the contents of the pack, and discuss future plans for dissemination and evaluation.

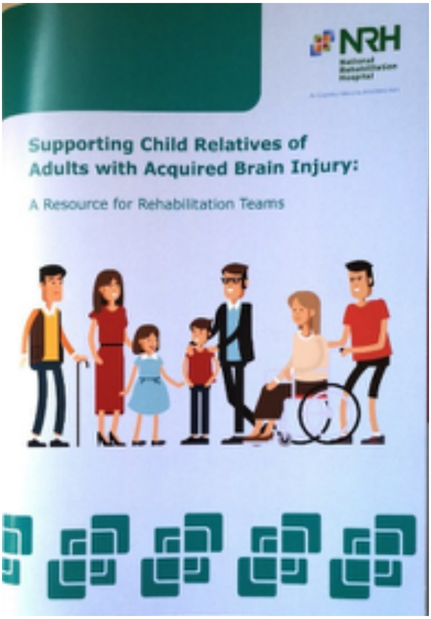
Methodology

The first step in the development of the resource pack was to carry out a scoping review of literature relating to the impact of ABI on children and families. A scoping review aims to map the body of literature on a topic area and it provides a rigorous and transparent method for mapping areas of research (Arksey and O’Malley, 2005). In undertaking the scoping review, search terms used included: parental brain injury; impact of brain injury on children; impact of ABI on families. In order to broaden the search, consultation was had with clinicians actively involved in the field of ABI, such as Dr Audrey Daisley, Clinical Consultant Neuropsychologist in the Oxford Centre for Enablement. Dr Daisley works extensively with children affected by familial brain injury and is an eminent writer in this area. She was the inspiration for the project and was extremely generous with her time, resources and publications.

Following completion of the literature review, discussion groups were held with members of the IDT in the NRH to ascertain their views on the relevance of the pack and their suggestions on its content. Consultation sessions were also held with social workers in the NRH, particularly those with experience of working directly with children.

An initial draft of the resource pack was piloted on one brain injury ward for approximately six months, after which members of the IDT were invited to give feedback on its usability. Verbal feedback was obtained from therapists who used the pack in interactions with children. The feedback was largely positive, with some suggestions regarding the design and layout. No major changes were made, and the text was then finalised.

‘Supporting Child Relatives of Adults with Acquired Brain Injury: A Resource for Rehabilitation Teams’ was officially launched in October 2018 in the NRH. Both internal and external staff were invited, and speakers at the launch included Dr Audrey Daisley, members of the NRH Social Work department, and a parent with a brain injury who spoke of his experience and that of his family. A workshop with Dr Daisley was also held, which offered people an opportunity to discuss how best to engage with children affected by parental brain injury.


NRH
National Rehabilitation Hospital

Supporting Child Relatives of Adults with Acquired Brain Injury:

A Resource for Rehabilitation Teams

Contents of the Pack

The pack is divided into three sections: Introduction, Interventions and Resources. The Introduction provides a background to the importance of involving child relatives in rehabilitation and highlights themes emerging from the current literature. The Interventions section provides practical tips on how to help children adjust to parental brain injury. Some examples include: give honest age-appropriate information to children; encourage families to keep children’s daily routines as ‘normal’ as possible; and invite children to observe and participate in therapy sessions where appropriate. This section also includes commonly asked questions by children and advice on how to answer them. For instance, for young children the brain can be explained with an analogy of a command station of a space ship, with the brain controlling how the body moves. Explaining brain injury in age appropriate terms will help to ensure children fully understand the reality of brain injury, and this section gives rehabilitation staff and other adults the tools to achieve this.

Section 3 contains a list of resources to help not only staff, but parents and anyone trying to help children understand and adjust to a relative’s brain injury. There are numerous books, games and websites that can help children and these are all referenced in the pack. The Resources section also includes a list of child support services in Ireland as well as handouts which serve as a quick reference for staff in explaining how a child may be affected by a relative’s brain injury and how to include them in rehabilitation.

The resource pack has an appendix, which includes three information sheets designed specifically for parents, which can be given to them when appropriate.

Findings from Literature Review

Several themes emerged from the literature review: the impact of ABI on child relatives; the impact of ABI on parenting capacity; the rehabilitation benefits of promoting resilience; and the benefits of family focused rehabilitation.

Impact of ABI on child relatives

While some authors focus more on the negative impact of brain injury on child relatives and others focus on the positive consequences, there is general agreement that a brain injury in the family has a long-lasting effect on children. Daisley and Webster (2008) discuss the challenges that children can face and categorise these into four main areas: 1) the direct impact of post-injury symptoms, such as when the injured person has behavioural difficulties; 2) role changes within the family; 3) social consequences of brain injury including job losses and financial difficulties; and 4) the impact of the brain injury on the non-injured parent and how this affects the parent child relationship.

In terms of the direct impact on children, the concept of ambiguous loss is a common theme, with authors noting the difficulty for children to grieve their parent, as the loss is not absolute but the parent may be changed emotionally and behaviourally (Butera-Prinzi and Perlesz, 2004). The social consequences of brain injury can have a significant impact on children. Butera-Prinzi and Perlesz (2004) note that children reported feeling abandoned by family friends and extended family. Brooks (1991) discusses the social isolation of families and states it is a marked feature for all family members following ABI, with some having no social contacts outside the close family. This increases the already high burden on these families. Butera-Prinzi and Perlesz (2004) assert that school was considered by children an escape from their problems at home.

Brooks (1991) discusses the high levels of subjective burden felt by family members five and six years post ABI, with families becoming lonely, isolated and cut off from support. He notes that there was a high level of separation and divorce at ten years post ABI. Webster, Daisley and King (1999) also found that 30% of marriages end in divorce within seven years of a severe ABI to one partner.

Rolland (1999) refers to the challenges facing children at particular stages in the life cycle of the family. For instance, a parent injured in the child-rearing phase of the life cycle will affect the family in different ways than a parent injured when his/her child is an adult. Children are progressing through their life cycle transitions, while at the same time their family has to cope with the injured parents' transition to a new level of ability and/or impairment. This can lead to differing demands and stresses on the whole family. DePompei and Williams (1994) allude to challenges in the life cycle of families after brain injury, and give examples of when a stage of the life cycle can be disrupted or even reversed. For example, a person with a brain injury may have to return to live with parents after having lived independently or with a partner. This can be challenging for both the person and the parents, and is further complicated if there are children involved. Children may have to adjust to new living arrangements, such as moving in with grandparents, or their injured parent moving out of the family home.

Impact of ABI on parenting capacity

Kieffer-Kristensen et al (2013) highlight the notion of diminished parental attention and ‘disrupted parenting’ and define disrupted parenting as “reduced parental support or less nurturing of the child”(Kieffer-Kristensen et al 2013: 61). This reduced support can be from both the injured and non-injured parent, and can include depression and stress of both parents, reduced boundary setting, marital conflicts and other problems. The authors’ hypothesis is that ABI families will have disrupted parenting and therefore more stress, leading to more emotional and behavioural problems in the children. An interesting finding from this study is that the stress in the non-injured parent impacted significantly on the child and led to emotional and behavioural problems. They argue that the stress on the non-injured parent, who has to try to fulfil the role of both parents and try to protect the child from further psychological distress, can take its toll on that parent and lead to significant stress levels. This in turn influences the child negatively, and can lead to emotional and behavioural difficulties. The importance of the well-being of the non-injured parent leads the authors to conclude that “one cannot adequately look at parental ABI without taking into account the entire family system” (Kieffer-Kristensen et al 2013: 67).

Pessar et al (1993) concur with this and argue that family based rehabilitation should look at depression and parenting behaviour of both parents when assessing the impact of ABI on children and families. Vitale Tiar and Dumas (2015) also refer to the challenges faced by the non-injured parent and note that the non-injured parent can feel more easily overwhelmed by children and find the task of bringing children up particularly difficult. They conclude that overall, “both injured and uninjured parents displayed less positive behaviour following ABI…less loving and accepting of their children…showed less interest and involvement in their activities” (Vitale Tiar and Dumas, 2015: 9).

Pessar et al (1993) refer to ABI as a major family stressor. They state that when there are psychological and social disruptions within the family this may influence children’s psychological and social well-being. They report on a study they undertook of 24 families, and found that 22 of the 24 families reported negative changes in children’s behaviour since the ABI. The most prevalent problem area according to the authors was the relationship between the children and the injured parents. They highlight that the injured parent no longer fulfilling the parental role caused significant problems for the children. This is further explored by Holloway (2014) who notes that the injured parent’s reduced capacity to fulfil his or her parenting role by, for example poor boundary setting, neglect and lack of attachment to children, can lead to an increased risk of post-traumatic stress symptoms in children.

Following an ABI, children may feel neglected and vulnerable and can internalise these feelings. The risk of Post-Traumatic Stress Disorder (PTSD) in children is a strong recurring theme in the literature. Kieffer-Kristensen et al (2011) postulated that 46% of children with a parental brain injury met the criteria for probable PTSD in the form of “intrusive thoughts, avoidance behaviour and arousal symptoms” (Kieffer-Kristensen et al

2011: 757). They also noted that parental ABI can lead to additional secondary stressors, which may increase children's risk of developing PTSD symptoms. These secondary stressors include: 1) diminished parental attention – the brain injured parent is usually less involved in the parenting role, as can also be the case with the non-injured parent who has more demands on their time; 2) tension in the marital relationship – this may threaten the child's feeling of safety and security; and 3) changes in daily life and routines – for example, the injured parent no longer collects the child from school. These secondary stressors, in conjunction with the traumatic experience of the brain injury event itself, poses a significant risk of traumatic stress on children. The authors conclude that the impact of trauma in children should be assessed, and that a more child-focused approach would help to to decrease children's post-traumatic stress symptoms.

The Rehabilitation Benefits of Promoting Resilience

It is evident from the literature that children can be impacted both positively and negatively by parental brain injury. Tiar and Dumas (2015) identify three methods of coping displayed by children and adolescents. Firstly, some children display pro-social coping. For example, they take on more responsibility in the home and in care tasks; and they feel empathy for the non-injured parent. Secondly, some children display anti-social coping behaviour, in which they exhibit anti-social behaviour at home and in school, such as temper tantrums, disobedience, anger and hostility. Thirdly, some children display asocial coping behaviours. These relate to children displaying depressive symptoms, such as negative mood, poor self-esteem, inability to feel pleasure, as well as feelings of loneliness and isolation.

The importance of peer relationships can help children cope with their parents' ABI. Moreno-Lopez et al (2011) highlight the value of peer relationships for adolescents and conclude that "peer relationships appear to have a crucial function as a link between adolescents' lives before and after ABI, enabling them to maintain a sense of normality and continuity" (Moreno-Lopez et al 2011: 1230). Friendships provided a break for the adolescents from their family and gave them space to be 'normal' adolescents.

A family resilience perspective recognises parental strengths and potential as well as limitations, and as such involves the potential for personal growth and transformation. Walsh (2003) sees a crisis such as a brain injury as having the potential to lead to more enriched and loving family relationships, and argues for the potential for family recovery and growth out of adversity. Nine key processes in family resilience are highlighted, and these processes outline the way in which resilience can help support families to 'bounce forward' from a crisis, and maintain positive family relationships.

Key Processes of Family Resilience (Walsh, 2003)

1. Make meaning of adversity – normalise and contextualise adversity and distress

2. Positive outlook – hope, perseverance, accept what cannot be changed

3. Transcendence and spirituality – faith, congregational support, healing rituals,

finding meaning and purpose beyond oneself and one's immediate troubles

4. Flexibility – open to change, adapt to fit new challenges, stability through disruption

5. Connectedness – mutual support, collaboration and commitment, respect differences

6. Social and economic resources – mobilise social networks, balance work/family strains

7. Clarity – clear, consistent messages, clarify ambiguous information

8. Open emotional expression – share range of feelings, mutual empathy

9. Collaborative problem solving – creative brainstorming, resourcefulness, shared decision making, focus on goals, prepare for future challenges

Butera-Prinzi, Charles and Story (2016) also discuss family resilience. They describe resilience as a dynamic process that can change over time, and at various points in the family life cycle, rather than being a 'fixed' family trait. They assert it is the role of the clinical team to look for this resilience and strengthen it in order to support families to adapt to their new life following an acquired brain injury.

The role of the rehabilitation team is further explored by Skippon (2013), who notes the three main dimensions of resilience, focusing on 1) identifying and developing resilience factors within the individual parents and children (such as flexibility and coping strategies); 2) resilience factors within the family (such as attachment relationships); and 3) supporting the family in maintaining social integration and networks. If the rehabilitation team adopts a more family centred approach and utilises a resilience approach to their interventions, it is hoped that more positive outcomes can be achieved for patients and their families.

Benefits of Family Focused Rehabilitation

It is clear that acquired brain injury has a significant impact on families in general and children in particular. As we have seen, there are several studies which highlight the effects on children (Butera-Prinzi, F and Perlesz, A 2004, Daisley et al 2009, Brooks 1999). It is therefore important that not only do professionals support the brain injured person to recover, but also their family, as this will influence rehabilitation outcomes and the family's wellbeing in general.

Holloway and Tyrrell (2016) assert that rehabilitation outcomes and goal attainment for persons with ABI is better in families that communicate well. They argue that working with uninjured family members has positive impacts on rehabilitation outcomes, and in turn has benefits on parents' ability to parent their children. They report on a study in which they looked at the benefits of supporting parents with an ABI to parent their children. This had benefits for both the injured parent in terms of their rehabilitation and for the child in terms of him or her remaining in the family home in a healthy family environment. They conclude that social work can play a central role in "the effective use of rehabilitation and support by the injured party, monitor risk, and reduce likelihood of harm" (Holloway and Tyrrell, 2016: 17).

Moreno-Lopez et al (2011) also refer to the benefits of a family focused rehabilitation and argue that how a family copes can have a positive impact on the rehabilitation progress of the person with the ABI. In the UK, there has been a growing emphasis on family focused rehabilitation with their ‘Reaching Out: Think Family’ (2007) document published by the Social Exclusion Task Force. Central to this policy is a belief that tailored, flexible and holistic services that work with the whole family can have a positive impact on families. It argues that working with the whole family can have preventative qualities by focusing on a family’s strengths and recognising problems early on. It promotes resilience and working with parents to help promote positive relationships, and social and emotional skills.

Daisley, Tams and Kischka (2009) also argue that families can have a significant role in helping people recover from ABI, but if they experience distress this can impede this role. Hence the importance of professionals recognising this distress and helping the whole family in order to help the injured person. Bowen (2007) alludes to the increasing emphasis on family focused rehabilitation in the UK and argues for the use of family therapy in this process. He asserts that this new emphasis on the family is based on “a belief that rehabilitation should involve a model for supporting families that is flexibly applied (Bowen, 2007: 344)” and that family support plays a critical role in recovery after brain injury.

Outcomes and future plans

Since the launch of the pack, the author has presented at several conferences, including the International Conference for Social Workers in Health and Mental Health, held in York in July 2019. As this is the first pack of this type to be developed there was a great deal of interest in the pack, and it has since been made available to teams working in brain injury rehabilitation in the UK and Australia. Initial feedback has been positive, and the plan is to administer a feedback survey in 2020 to ascertain the value and effectiveness of the pack for rehabilitation teams.

Within the NRH, there have been positive outcomes following the adoption of the resource pack as a tool for therapy teams. When goals are being set with and for patients with ABI, there is greater appreciation and consideration of goals around parenting and childcare tasks. Anecdotal evidence would suggest that there has also been an increase in the number of children attending therapy sessions, such as speech and language therapy and occupational therapy, as well as one-to-one sessions with social workers.

While this pack was primarily designed for staff working in brain injury rehabilitation teams, it can also be helpful for non-healthcare workers, such as teachers. Publication of this resource pack is the first phase of the research. The second phase is to adapt the pack to meet the needs of non-injured adults in helping them communicate with their children. In order to commence this phase, a working group of non-injured parents will be set up, whose task will be to give feedback on the current staff pack and draft an adapted version for parents. A draft parent pack will then be piloted for six months, before a final resource pack for parents will be published. The third phase is to adapt the pack as an educational tool for socials workers who may not have experience of brain injury, but who are faced with the challenges of supporting children and families affected by it.

There is also work being undertaken to develop the pack for use with children affected by parental spinal injury, which would be beneficial for children of spinal injury patients in the NRH.

Conclusion

Through working with families impacted by ABI, a gap in service was identified by the author. The research supported this and indicates that children should be included in the rehabilitation process. This not only helps children, but has a positive impact on a brain injured person's rehabilitation outcomes. The literature provides helpful insights into how children are affected by brain injury, and is a useful starting point in looking at how to ensure rehabilitation can be more inclusive of children in the future. There is considerable evidence illustrating the benefits of including children in rehabilitation for both the injured person and the whole family.

The development and adoption of 'Supporting Child Relatives of Adults with Acquired Brain Injury' to address this gap in service highlights the importance of social work practitioners engaging in research that has a practical application, evidenced by the positive response the pack has received. It is hoped that further research to complete phases two and three can be completed by the end of 2020.

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SERVICE USER INVOLVEMENT AND COPRODUCTION IN SOCIAL WORK EDUCATION AND PRACTICE DEVELOPMENT: A NARRATIVE REVIEW

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Keywords

Service User Involvement; Service User Participation; Coproduction; Social Work; Social Work Education.

Abstract

Aim: To examine empirical research studies relating to the involvement of service users and carers in social work education and practice.

Method

This was a small-scale narrative review based on a systematic search of three electronic databases: PsycINFO, Social Care On-Line, Social Services Abstracts. The studies were summarised, and primary study findings were thematically analysed. The review is introduced, and study findings are discussed, with particular reference to the context of Northern Ireland social work practice.

Findings

Eleven studies were retrieved; nine from the UK, one from Australia and one from Netherlands and Belgium. The majority of literature retrieved in the review related to service user involvement in social work educational settings. Three main themes were identified from the included studies, these were; meaningful involvement, challenges and outcomes of service user involvement. There is a significant focus on what factors make the involvement of service users meaningful. With clear messages from service users that they regard feeling valued, making purposeful contributions, knowing the outcomes of their contributions and being paid as key indicators that their involvement is meaningful. Service users, carers, lecturers, social workers and social work students offer positive feedback on service user involvement and coproduction. Although, the literature suggests long established practices involving service users in educational settings, the work is not problem free and the range of challenges and barriers as identified by service users, professionals and academics are discussed. In terms of outcomes, these are largely articulated from the perspective of those service users or

students involved in service user projects. Service users experienced an increase in their own personal skills, development, a growth in confidence and an increase in social opportunities were highlighted as being crucially important to them. Social work students report valuable insights into service user issues, an increase in knowledge and skills and opportunities to reflect upon their core social work values.

Conclusions

Whilst, the experience of service user involvement is largely positive, more focus on the inherent challenges and barriers to the involvement of service users in social work education would be prudent. There is an opportunity to focus on outcomes, more explicitly, identifying the factors that make involvement meaningful for the individual and effective in the development of social work practice. Empirical research has focussed on the education and training of social workers and the contributions that service users can make to it. There is limited research evidence to reflect how the approach is implemented in statutory social work practice. More research may contribute to the limited evidence base and development of useful frameworks and models that can be practically applied across all social work settings.

Introduction

Service user involvement, in the education and training of social workers has gathered momentum in the UK since the early 2000s (Duffy, Chaitali, & Davidson, 2013). In the wider social work practice context, there has been a long history of service involvement. Irvine, Molyneux, & Gillman, (2015) suggest that it is not a mainstream approach, but Rantamaki, (2017) suggests there is now some momentum to involve service users, in more meaningful ways, across social work practice areas. Rantamaki suggests that the increased focus can be associated with efforts to create more sustainable, economically viable, ways of organising social care and supporting people and communities. This, more recent, interest in the area is highlighted by the emergence of coproduction. The term coproduction is used to suggest a deeper engagement between service providers and service users during service development and delivery (Boyle & Harris, 2009). Stephens, Ryan-Collins, & Boyle, (2008) argue that it is an effort to harness the strengths and abilities of individuals to improve the delivery of public services. It should be conceptualised as a process where service users/carers work alongside staff (Boyle, Clark, & Burns, 2006).

Service user involvement is clearly legislated for, and now enshrined in policy statements in Northern Ireland (Askheim, Beresford, & Heule, 2016). For the past decade it has been a legal requirement, in Northern Ireland, to ensure the active and effective involvement of service users, carers and the public in Health and Social Care policy development and the delivery of training and services (DHSSPS, 2009). The ten year plan for Health and Social Care transformation, set out in 'Health and Wellbeing 2026, Delivering Together' is driving a move away from crisis management and reactive responses toward more inclusive and collaborative service delivery, in partnership with service users and carers (DOH, 2016).

Coproduction is set out as the preferred approach to practice, service development and strategic delivery in phase two of the Social Work Strategy 2017-2022 (DOH, 2012).

This approach is a strategic priority for the Quality Improvement Strategy that sets out aspirations for the active involvement of frontline practitioners and service users in improving practice and service delivery (DOH, 2011). Furthermore, in response to the growing crisis in adult social care the Department of Health has set out 16 proposals that aim to bring about radical change by putting "citizens at the heart" of decision-making, design and delivery of services (DOH, 2017).

The legal mandate is clear, but it should be noted that, there is some scepticism about the current momentum around coproduction. Cameron, Moore, Nutt, & Chambers, (2019) raise concerns about rhetoric around the involvement of service users, suggesting there is a risk of submerging service users in market driven and consumer-based models, to the detriment of more inclusive and rights-based approaches. It has been argued that the motivation to make these changes is related to political and economic challenges facing the welfare state (Pestoff, 2009; Organisation for Economic Cooperation and Development [OECD], 2011). Coproduction has been argued to be a form of circumvention, of state responsibility to provide quality services in the social care sector.

The current authors would suggest that, in the main, coproduction is used to drive service quality, but would acknowledge commentators concerns that it needs properly resourced, providing training, expertise, and support for those involved (Evans, 2012). "Coproduction may be 'value for money', but it usually cannot produce value without money" (Bovaird & Loeffler, 2012 p. 1137). In this, sometimes contentious, context the current review has attempted to draw together findings to date from empirical research on service user involvement and coproduction. We have cast a wide net in an effort to capture any literature, which can provide an insight into efforts to involve service users.

We were interested in providing an insight into how this emerging field of study is developing, any early indications of research priorities and, crucially, any insights into learning which can help inform future efforts to engage service users and carers in social work training and service design and delivery.

Method

The literature search followed guidance on systematic bibliographic searching (McGinn, Taylor, McColgan, & McQuilkan, 2014; Reed & Baxter, 2009). Search terms piloted for two concept groupings: service user involvement; and social work training, policy and practice. The search formulae were deployed in electronic databases: PsycINFO, Social Care On-line and Social Services Abstracts. No date filters were applied however material returned relates to studies carried out during the last decade, with the earliest study dated 2009. The last search was carried out on 19th January 2018. A total of 581 articles were returned. These were screened by the first author using a priori criteria relating to the topic area, accepted definitions of service user involvement and coproduction, and the inclusion of social work training, practice, policy. Empirical research evidence was identified with particular attention paid to quality of methods used (Best, Taylor, Manktelow, & McQuilkin, 2014, p. 1).

Following initial screening, the full text of sixty-seven studies were sourced and screened in more depth (as outlined in Fisher, Qureshi, Hardyman, & Homewood, 2006). Eleven of these studies were deemed to satisfy the selection criteria. Data was extracted from each study as follows: country of origin, study design, sample size, method of data collection and the main findings of the study. A thematic analysis was used to identify key themes across the resultant dataset (Popay, Roberts, Sowden, Petticrew, Arai, Rodgers, Brittens, Roen, & Duffy, 2006).

Findings

The review identified eleven studies relating to service user involvement in social work education and practice development. Of the included studies, eight were qualitative and three were mixed methods. All, but one of the studies, (Davies, Gray, & Webb, 2014) relate to the education and training of social workers. We found that primary study findings fell into one or more of three overarching themes: meaningful involvement, challenges/barriers, and outcomes.

Meaningful Involvement

This was arguably the most dominant theme across primary study findings. The majority of studies (Anghel & Ramon, 2009; Davies, Gray, & Webb, 2014; Driessens, McLaughlin, & Doorn, 2016; Levy, Aiton, Doig, Dow, & Brown, 2016; MacSporran, 2014; Rooney, Unwin, & Osborne, 2016; Unwin, Rooney, Osborne, & Cole, 2017; Webber & Robinson, 2012) offered insights into factors that made the process meaningful from a service user perspective, and the concept of empowerment featured significantly. In a mixed methods study MacSporran, (2014) identified several factors, from a service user perspective, that contribute to their involvement being meaningful: undertaking purposeful, organised, structured roles with remuneration for contributions made, or work carried out. Other studies have reported that service user involvement has been meaningful due to the inherent opportunities for educational and career development (Davies et al. 2014).

Five studies provided examples of greater user control, where service users undertake roles as co-researchers (Rooney et al. 2016; Unwin et al. 2017; Tanner, Littlechild, Duffy, & Hayes, (2017); Webber & Robinson, 2012; Driessens et al. 2016). Webber & Robinson, (2012) suggested that the regular and sustained involvement of service users is required to build relationships, to support richer contributions and realise meaningful involvement. Levy et al. (2016) describe how the absence of some of these factors can contribute to service users' feelings of disempowerment.

Finally, Farrow (2014) reports on key messages from professionals and academics in his study. Most notably that service users are aware that their involvement is tokenistic, when it is tokenistic. Farrow argues that service users must be involved in purposeful tasks, not simply because professionals regard it as the right thing to do or because it is a legal or policy requirement.

Challenges

Anghel & Ramon, 2009; MacSporran, 2015; Farrow, 2014; Rooney, et al. 2016; Davies et al. 2014; and Webber & Robinson, 2012;) all explored the challenges or barriers to service user involvement. In a peer led study, Rooney et al. (2016) focus extensively on barriers experienced by service users from a service user perspective. Findings categories related to; accessibility, organisational barriers and personal barriers. In relation to organisational barriers, there was recognition of the difficulties of recruiting new service users, and issues with diversity of those service users currently involved. The timing of meetings, difficulties in arranging respite care for relatives, poor communication, excessive travel distance and low rates of remuneration were sub-themes relating to accessibility.

Davies et al. (2014) describe how service users articulated such operational challenges as a lack of clarity around their role and function. Limited opportunities to contribute to decision-making processes and an absence of feedback on the outcomes their work. Some had withdrawn from their roles, feeling labelled and having encountered a lack of respect for their lived experience. They identified a need for more training and support to develop the skills and knowledge required to contribute effectively.

Anghel & Ramon, (2009) underline the main barriers to service user involvement as insufficient funding and resources. The impact places additional demands and pressures on professionals. Therefore, detracting from the time they have to create the conditions and structures required to support service users and advance the approach. In a more recent study, Tanner et al. (2017) followed newly qualified social workers into the workplace. They reported excessive workloads and stressful conditions, along with other factors related to culture, values and attitudes of colleagues and managers were identified as the main barriers to continuation of service user involvement approaches outside of university setting (Tanner et al. 2017). Farrow, (2014) also highlighted practitioner workload pressures as a potential problem, suggesting that professionals cannot undertake service user involvement in a meaningful way if there is no recognition or support for the challenges that they face.

Outcomes

Eight studies reported findings related to the outcomes of service user involvement: Angel & Ramon, 2009; MacSporran (2015); Driessens et al. (2016); Unwin et al. (2017); Davies et al. (2014); Tanner et al. (2017); Levy et al. (2016); Hughes (2017). This theme captured findings that fell outside the focus on how service users were involved to more scrutiny of what actually happens because of their involvement (Levy et al. 2016, p. 868).

Where service users have articulated their own personal outcomes, they describe enhanced user control. Good outcomes for service users are directly derived from the opportunity to engage in purposeful work. Where they feel appreciated, valued, and included and have the opportunity for skills and knowledge acquisition that contributes to increased feelings of independence, personal confidence and competence (Macsporran, 2015). Similarly, Davies et al. (2014) reported on service users' personal outcomes as increased confidence, enhanced feelings of worth and purpose.

The study carried out by Angel & Ramon, (2009) partially focused on student learning outcomes and found that students reported a deeper understanding of lived experience and a greater awareness of the impact of social services on individual's lives. Studies that are more recent, have reported similar findings, students feel they achieve a greater insight into service user needs and a greater understanding of the importance of relationships from the input of service users (Driessens et al. 2016). In addition, Unwin et al. (2017) find that students experienced changes in terms of their perceptions of people with disabilities and reported that this learning would impact on their future practice as social workers.

Hughes (2017) took an open-ended narrative approach to seek insight into the impact of service user involvement on students' subsequent practice after qualification. Findings were organised under four central themes, enhanced awareness of the lived experience; taking on board suggestions of good practice from service users and carers; developing a more critical 'real life' understanding; culture of recognising service users and carers as experts.

Discussion

This paper endeavours to bring together a modest number of published empirical research studies relating to the involvement of service users in social work education and practice development. The included studies illustrate the innovation and creativity that social work educators have demonstrated over the past decade. In all cases, it was clear that primary study authors were aligned to the general view that service user involvement is good practice and fits well with the values of the social work profession.

We would also point out that conversations are changing, in relation to service user involvement. There is less focus on how service users are involved and more on how meaningful and effective the involvement has been (Levy et al. 2016). Establishing what is meaningful and from whose perspective presents a challenge in itself. The findings suggest that there is no real mechanism to do this. Farrow, (2014) suggests the need to set out a criteria to clearly define what meaningful involvement is. Critical perspectives from service users are valuable and can provide a good insight into how they really experience involvement with professionals, and although, the evidence suggests that service user involvement is well established in social work education, a range challenges and barriers remain.

Student learning outcomes dominate the discussion around service user involvement (Unwin et al. 2017) in social work education. Although, this is valuable in its own right, results are often inconclusive; more robust evaluation is needed to produce hard evidence of transformative change in learning, practice and the behaviour of students (Rooney et al. 2016). Robust methods are needed to consider the impact of such service user involvement in educating future social workers and how subsequent practice is changed or improved as a result.

There are only two studies in the current review that have considered the impact or outcome of service user involvement on social work students' subsequent practice (Tanner et al. 2017; Hughes 2017). Hughes goes some way toward establishing the value in terms of the difference that is made to social work interventions and how social workers interact with service users.

Only one study, (Davies et al. 2014, p. 119) relates to social work practice itself and interrogates notions of service user involvement as a vehicle of empowerment and social justice. Suggesting that there is a need to break down existing barriers by changing attitudes and redistributing power. The included studies illustrate the potential dividends of enriching the learning and practice of social workers and more importantly including and empowering the people social workers support. The social work profession has an opportunity to build on this work and integrate the approach as a mainstream social work method. Farrow (2014) suggests that there is a gap between policy and practice, in that the rhetoric around service user involvement in policy does not always translate directly to social work practice.

Conclusion

This review brought together some of the broad themes that emerged in empirical research studies related to service user involvement. Collectively, the studies highlight the value of service users' involvement to the professional development of social workers. They map the significant progress over the past ten years, in developing genuine partnerships with service users and the cultural shift that was required in order to make this possible. This has required those working in educational settings to be open to new learning and knowledge and more importantly open to power sharing. It is notable that the term coproduction did not feature significantly in the published research. Nonetheless, there was an abundance of evidence that demonstrated partnership and collaborative working, that went well beyond the basic notion of service user involvement.

There is some exploration of the inherent challenges and barriers, with some concern about resources, funding and time are core themes. There are concerns about demands placed on service users and about the support required for meaningful involvement. More critical examination is required on the day to day pressures and demands for service users and for those professional staff willing to engage in such innovative work practices. In addition, there is a need for on-going evaluation of the difference that involving service users makes to both social work practice and to service user outcomes.

Within the current review the majority of studies, with the exception of one, focus on projects implemented in university settings. It would be helpful to gain insight into what is stopping it from becoming mainstream in the workplace. Particularly, when the evidence is overwhelmingly pointing to the fact that involving service users presents opportunities for social workers across all settings, and promotes rights-based social work, better connected with service user groupings and communities.

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TALKING POINTS: DEVELOPING THE CARE ALLIANCE IRELAND DISCUSSION PAPER SERIES FOR STUDENTS, RESEARCHERS AND FRONT-LINE WORKERS

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Zoe joined Care Alliance Ireland in January of 2015, as Policy & Research Officer. Zoe has qualifications in Social Work, Social Policy and Disability Studies, and her past work has included working with a number of academic and voluntary sector organisations in frontline support roles as well as research, teaching, and policy development. Zoe coordinates the Care Alliance research and policy functions, along with supporting member organisations to input into Care Alliance Ireland documents and submissions. Zoe commenced work on the Doctorate in Applied Social Studies in University College Cork in October 2017, with a focus on family caring issues. Her doctoral research is concerned with the experience and support needs of family carers who identify as a sexual and/or gender minority in Ireland.

Abstract

Care Alliance Ireland is the national membership organisation for not-for-profit groups who support family carers in Ireland. In 2015, the Care Alliance Discussion Paper Series was launched, to create accessible, high quality and relevant research documents which discussed a potentially difficult or minority topic, relevant to family carers. The series has grown in the intervening years and makes use of literature reviews, national and international research and makes recommendations for professionals working with family carers. This paper details the Discussion Papers Series from inception into the future.

Introduction

The Care Alliance Ireland Discussion Paper Series was developed in 2015, to bring together current and recent research and good practice examples in the field of family carer supports, and to make this information more accessible to policy makers, family carers, students, researchers, practitioners and other relevant stakeholders. This paper was presented at the 2019 All Ireland Research in Social Work Conference in Dublin, Ireland, and will detail the development, writing, dissemination and practice implications of the series.

Care Alliance Ireland and Research

Care Alliance Ireland was established in 1995, in order to create a more cohesive Family

Carer sector in Ireland, developing links between the disability, family carer support, illness and related sectors. Family carers have always been the backbone of the Irish health and social care system, enabling more people with disabilities and other conditions requiring long term care and support to live at home, in the community, for as long as possible. From our inception, research and policy work have been at the core of the work of Care Alliance, and have always been conducted with an eye to adding value to practitioners working to support family carers, such as nurses, home care workers, social workers and others.

In general, Care Alliance Ireland's research function is spread across three distinct but intertwined activities. We place collaboration and inclusive research at the core of our work, and in the past have successfully partnered with the majority of academic research centres in Ireland, including UCD Dublin, Trinity College Dublin, University of Limerick, Maynooth University, and University College Cork. We understand the academic expertise which these university-based research centres contain, but we also understand that the majority of on the ground supports provided to family carers are provided by not-for-profit organisations – the value that we have brought to such academic projects is a connection between policy, practice and indeed access to connect with relevant individual family carers and increasingly our not-for-profit member organisations. Our collaborative projects have included work on the resilience of family carers of people with dementia, in collaboration with the UCD School of Nursing, Midwifery and Nursing Systems (Deegan and O'Sullivan, 2019); a project investigation the concept of 'benefit finding' and it's applicability to the family carer sector with the University of Limerick School of Psychology (Gallagher and Care Alliance Ireland, 2015); and the experiences of former family carers with Trinity College Dublin (McCarron et al., 2011).

In addition to collaborative academic based research projects, we have also conducted our own primary research into various topics of relevance. We use innovative methods where possible, for example a 2018 paper which utilised Freedom of Information requests to Community Health Organisations across the country to determine the volume and duration of waiting lists for those assessed as requiring home support service (Care Alliance Ireland, 2018a). In addition, we publish results of surveys we undertake periodically, either as a standalone dataset or as part of our various publications.

Finally, many of our publications involve – either as the main methodology or as a significant aspect of the research – a comprehensive literature review. The most obvious reason for this is that a literature review can 'set the scene' for those unfamiliar with a particular topic and is generally a standard expectation for traditional research endeavours. However, we are keenly aware that many policy makers, managers and practitioners who are working outside of the academic sector simply will not have access to traditional journal articles and research findings as many academic institutions and departments, not to mention funding bodies, still require publication of results and findings in traditional journals which are primarily kept behind paid firewalls. By finding ways to make these discussions and research available to key stakeholders with little to no access – which includes family carers themselves – we can maximise the capacity of those key stakeholders. In addition, all documents we produced are written to be accessible, and in plain English.

One of the core facets of the work of the Care Alliance is to combine these research 'elements' and produce quality publications which can add value to the not-for-profit and public sectors who have an interest in issues facing family carers in Ireland today. Of particular interest is the Care Alliance Ireland Discussion Paper Series, which is the focus of this article.

Conceiving the Series

The series began in 2015, as a way to highlight some of the core issues facing family carers and their support organisations directly. Care Alliance Ireland is a membership organisation made up of not-for-profit groups across Ireland who work, in some way, with family carers. We were aware of excellent work taking place across the sector, and of research being conducted in academic institutions and did not see the benefit in duplicating either. We quickly realised, however, that there were some topics that our membership struggled with, in particular with topics where little to no information was available. These usually take the form of awkward, sensitive or 'taboo' topics, yet they have the potential to cause significant difficulties for family carers and their supporters if they remain unaddressed. With little to no information available on these topics, in particular for those practitioners most likely to be providing supports, we saw an information gap. As the primary author of the series, I knew that it would be important to utilise some of the skills I had developed in my social work training – being willing to begin and continue difficult conversations and creating accessible information – in writing these papers. If social workers, nurses, community workers and other not-for-profit groups could not engage with the material, then the series would be a poor use of limited resources.

In general, the method for creating the various papers within the series have followed a similar path. As Policy & Research Officer I am in touch with and contactable by members, academics, students and any other stakeholders, and remained and continue to remain open to suggestions as to possible topics for discussion. An example of this is the development of Paper 2: Intellectual Disability, Family Caring and Role Reversal. (Care Alliance Ireland, 2015). We had been approached by some members of our organisation who had noticed that many of the adults with intellectual disabilities within their services, and who lived at home, were increasingly taking on caring roles for their ageing parents, and this was causing some concern for the whole family wellbeing. The support workers in these organisations were unsure how to manage this change; who was their 'client', and who was the family carer now? How did this role reversal impact on other issues like confidentiality, or access to medical treatments? We ourselves did not have the answers, and so the paper was written and disseminated as an investigation into the topic.

For other topics, we were inspired by discussions with family carers themselves, for example Paper 7: Romancing The Carer - Intimate relationships and Family Caring (Care Alliance Ireland, 2017), and Paper 8: Difficult Relationships and Family Caring (Care Alliance Ireland, 2018b). Both are incredibly difficult topics – how do you begin to discuss how being a family carer can impact your intimate and sexual relationships? Indeed, given the overarching narrative in the media and in research and support which paints family carers as selfless, loving, and generous, how do you begin a supportive conversation with someone who feels forced into providing care to someone they may not like, or who may even have been, or is currently, abusive towards you? Carers that I spoke to informally on these topics wanted to be able to have these conversations but knew that those in support roles would not be comfortable doing so- or at least they did not believe they would be open to them.

Writing the Papers

Once the theme of each paper is confirmed, a brief literature review is conducted which incorporates academic journals and databases, general web searches and searches of grey literature. In order to comprehensively examine the research and policy landscape of the topic, it is important to us in Care Alliance not to rely exclusively on academic journal material, as there is some significant research work being undertaken and published independently by organisations outside of the academic landscape. By highlighting this work alongside traditionally published academic material it becomes clear that the not-for-profit sector has real added value in research.

As the series has developed, we have also added in focussed recommendations and proposed responses section, which has the added function of forcing a focus on practice responses and outcomes, rather than simply being a descriptive body of work. In conversation with members of the Care Alliance research sub-committee (who review each paper prior to publication) we aim to include proposed policy responses along with suggestions for further research, and proposed responses from carer support groups and allied health professionals.

This focus on concrete proposed responses has been welcomed by the readership of the series, some of whom have informally reported to me that some of the recommendations in various papers in the series have formed a ‘jumping off’ point in reflection both individually and, in some cases, at team level within organisations and departments.

In as much as we do make recommendations and proposals for follow-up responses at macro and micro levels, a key characteristic of the Discussion Paper series is that we use them to ask more questions rather than simply to provide answers. For many of the topics which we have included in the Series, there simply are no ‘right answers’ – difficult questions and topics cannot be ‘solved’ in the course of an 8,000-word paper. However, since the conception of the series, one of the key goals was to begin the conversation and add to the debates around certain key issues.

Getting Awkward

As mentioned earlier, one of the key characteristics of the Discussion Paper Series is that across the ten papers published to date, there exists some level of ‘awkwardness’, ‘taboo’ or tension within the topics, which can be seen from their titles below;

- Discussion Paper 1: Defining Carers
- Discussion Paper 2: Intellectual Disability, Caring and Role Reversal
- Discussion Paper 3: Online Supports for Family Carers- Options & Experiences
- Discussion Paper 4: The Wisdom of

Family Carers

- Discussion Paper 5: “We Need to Talk About It”- Stigma & Family Care
- Discussion Paper 6: Disability and Family Carer Policy - Challenges and Responses
- Discussion Paper 7: Romancing the Carer - Intimate Relationships and Family Caring
- Discussion Paper 8: Difficult Relationships and Family Caring
- Discussion Paper 9: Family Caring and Minority Populations
- Discussion Paper 10: Rural Carers in Ireland - Challenges & Opportunities

As a not-for-profit organisation, Care Alliance Ireland enjoys a certain flexibility and freedom when it comes to our research activities and outputs – whilst the post of Policy & Research Officer (and subsequently, the development of these documents) is funded significantly by the Irish government (as part of the Scheme to Support National Organisations, through the Department of Rural and Community Development), we have been free to develop the series into one which is practice driven, and above all is useful for researchers, practitioners and family carers, with the overall aim of improving service and support provision. Often, when applying for specific funding for particular research, funding bodies are concerned with ensuring ‘value for money’, in that the research and its outcomes, recommendations and publications are relevant to the largest number of family carers. However, this can mean that those struggling with minority issues – regardless of the severity and impact for that person, or family, are often left feeling that they are alone in their challenges. It also means that professionals, whose remit it is to support family carers however possible, or at least to support the family as a whole, are left wondering how to address a particular issue.

It also can act as a ‘jumping off’ point for discussions between inter-disciplinary teams to acknowledge that there may be more complex challenges within the families they are supporting, and in particular for the family carers who are often (but not always) not actually the focus of their service. A good example of this is Paper 7, which discusses some of the issues facing family carers with regard to intimacy and sexuality within relationships. The inspiration for that paper came from a very fruitful discussion with some family carers who were struggling with the impact of caring for their spouses, and how that was affecting their romantic and sexual lives. They spoke about wanting to raise the topic with someone, but not knowing how – and how much they would have appreciated knowing that they could speak about these issues without being made feel like they were shallow or being a ‘bad spouse’. Recognising that family carers are not always selfless, or ‘saintly’, and that that is perfectly normal would be of great support to them. We recognise that not all health and social care professionals will be comfortable raising this (or similar) issue, but it is important that the information is there to support them to get more comfortable with these potentially awkward topics.

Likewise, there has also been an opportunity to raise issues which many professionals may not have thought about, in particular as they relate to minority groups such as the LGBTQI+ community, the Travelling Community, religious minorities and others. Often this lack of cultural awareness does not come from a position of negativity, merely of ignorance. However in a changing Ireland, it is critical that professionals who are supporting family carers understand that whilst the ‘average’ family carer in Ireland is likely to be a straight, white, Catholic female in their 40’s and 50’s, this does not mean that services and supports should remain responsive only to that cohort of family carers (Hughes, 2018). The core issues facing many of these carers will be similar regardless of sexuality, gender identity, religion or race, however the solutions that are appropriate may be very different.

Dissemination

Core to the success of the series has been the dissemination strategy developed to increase readership of the series. The papers are all available on the Care Alliance Ireland website and have been downloaded close to 20,000 times (across all ten papers). In addition, the papers are uploaded to Lenus, the Irish health research repository; to international databases such as the Eurocarers research portal; and sent directly by email to our membership and those on our distribution lists, and we use social media to increase the reach of these documents even further. Furthermore, they regularly form the basis of presentations at sectoral events or our AGM’s. A limited number of printed copies are available directly from Care Alliance Ireland.

Feedback

The series has received almost exclusively positive feedback, in particular from professionals working in health and social care and family carers.

“Read your discussion paper on caring and stigma last week, thought it did a very good job of broaching what’s an interesting issue and one generally approached obliquely through another subject, but quite unexplored by itself.”

“I just wanted to let you know how interesting and useful I found your discussion paper on carer terminology. This is a huge issue for us in Denmark, so I have already shared the paper with several others and I hope to use the spring meeting of our national network of carer organisations and researchers to start a debate on how we in Denmark can accurately and sensitively refer to carers in our own language.”

We have also received feedback that the papers are being shared amongst teams where family carer support is not their organisations core activity, but that the series is a useful way for professionals who may come into contact with family carers at some point to understand some of the issues that may be facing them. Likewise, some feedback from family carers has shown that the topics addressed can be helpful in feeling less isolated;

“As a family carer I couldn’t argue with any of the findings and comments made by carers in the report. I think is an accurate picture of how many carers feel. I found their comments in fact very reassuring often what I think, feel and know but don’t say. As a result, I feel closer to other carers even though I don’t know them”.

However, not all feedback has been positive. Due to the challenging nature of some of the papers – in particular those relating to intellectual disability – we have received feedback from a small number of family carers that the views presented are not accurate, and that the service and policy responses suggested would not be well received. We do encourage discussion as a key component of the series and have published replies to the papers in our newsletter, with the aim of continuing conversations.

Future Plans

With ten published papers in the series, it has been a useful exercise to reflect on the direction of the series, and what direction it should take in the future. We in Care Alliance are keen to build on the success of the series so far, and the feedback received which indicates that the papers are being used in teaching, supervision and daily work with family carers.

We are keen to co-author papers in the series with other organisations, researchers and family carers, and to expand the series accordingly. Many of the most recent topics have been particularly ‘heavy’ in nature, which in many ways does not reflect the positive aspects of family caring, and the resilience and daily lives of Irelands family carers. Whilst raising difficult and less-researched topics has been a core component of the series to date, it may be timely to publish some which celebrate family carers, rather than focus of challenges and difficulties.

Conclusion

The Care Alliance Ireland Discussion Paper Series has been developed over the course of four years to foster discussion on challenging and awkward topics faced by family carers, and to add to the knowledge base and accessible information available to professionals working with them. Feedback has been overwhelmingly positive, with topics ranging from language use, to stigma, to sexuality and race. We have been pleased to learn that the series is being used as a teaching aid, a research aid and indeed a practice and policy development aid by many disparate groups across Ireland and internationally. The challenge for Care Alliance Ireland now becomes how to continue to produce these documents in an inclusive and accessible manner, with topics of continued relevance to family carers.

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SPACES, PLACES AND YOUNG PEOPLE: THE IMPORTANCE OF YOUTH PARTICIPATION AND WIDER COMMUNITY ISSUES IN SOCIAL WORK

Author: Jayne Groarke

Jayne Groarke is a recent Social Work Masters and Bachelors of Social Science Graduate at University College Cork. As part of her Master's degree, Jayne completed a piece of research with community partners through the CARL project (Community Active Research Links).

Abstract

According to Ho et al. (2015, p. 52-62); *"Youth participation refers to the active engagement and real influence of young people, not to their passive presence or token roles in adult agencies."*

Youth participation is a right according to the United Nations Convention on the Rights of the Child (1989) (Children's Rights Alliance, 2010). Ireland was the first country in Europe to have a national children and young people's participation strategy (Department of Children and Youth Affairs, 2015). Ireland's current national children's strategy - 'Better Outcomes Brighter Futures (Dcya, 2014) sets out a number of ways in which the country intends to support children and young people to insure that their needs are met, that their voices are heard and that their rights are respected. Tusla (Ireland's Child and Family Agency) also has a 'Youth Participation Toolkit' (Tusla, 2016) for practitioners to assist them in enabling children and young people to be involved in decisions that affect them.

The importance of youth participation is highlighted in theory but how does it translate into social work practice? In this research, youth voices were obtained by conducting semi-structured walking interviews with young people from Fairhill, a highly populated disadvantaged urban area of Cork City. Findings highlighted limited opportunities for youth participation in the community, the need for increased youth participation in communities that are deemed to be 'disadvantaged' and to place an increased emphasis on an ecological systems approach to social work practice when working with service users.

This paper will consider why listening to youth voices and encouraging youth participation are relevant to social work practice. It will explore youth voices and ways in which youth participation should occur according to the young people who took part in this community-based participatory piece of post-graduate research.

Key Words

Young people, youth participation, community-based participatory research, walking interviews, ecological systems approach.

Background to the Research

Fairhill is considered to be one of the most disadvantaged parts of Cork City (Cork City Council, 2019) with a high youth population

(Healthy Cities, 2018). RAPID is a government programme whose primary aim is to improve disadvantaged communities:

"Revitalising Areas through Planning, Investment and Development (RAPID) works with communities across Cork City focusing on areas designated as disadvantaged" (Cork City Council, 2018).

Fairhill is part of the four rapid areas in Cork.

The four RAPID areas in Cork are:

- Knocknaheeny/Hollyhill/Churchfield
- Blackpool/The Glen/Mayfield
- Fairhill/Gurranabraher/Farranree
- Togher/Mahon/Ballyphehane" (Cork City Council, 2019)

The overall population of Fairhill has significantly grown over the last decade, with a number of local authority housing estates built in the area. However, there are a lack of services and facilities to cater for this growth. Fairhill was also affected by the economic crisis where building and development ceased for some time in the area.

While the area has two community houses, they are too small to cater for everyone. There is an assumption by the community partners and youth facility working group that a designated youth facility (with a larger capacity) is required in the area to meet the needs of young people.

This research was a community-based participatory project involving University College Cork, Community Active Research Links Project (CARL), Fairhill Community Association, Cork City Council and Cork City Partnership. The community partners requested a piece of research to be conducted with young people from Fairhill.

Objectives of the Research

The primary objectives of the research were as follows:

- Obtain some of the voices, views and opinions of young people in Fairhill.
- Identify the needs of young people in Fairhill and how they can be met in their community.
- Determine whether there is a need for a youth facility in the area and if so, what would it offer.

Methodology

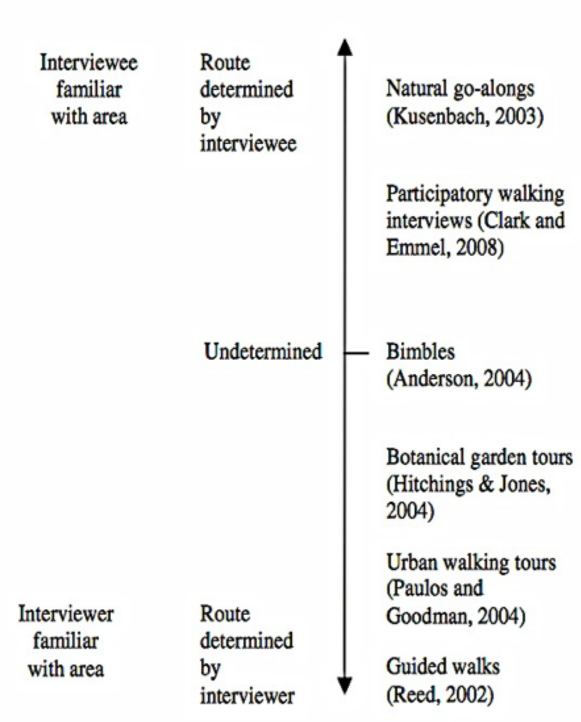
Six participants (residing in Fairhill and between the ages 12-18) were recruited from a number of youth services in and around Fairhill.

Ethical approval was granted by The Masters in Social Work Ethics Committee and The Social Research Ethics Committee (SREC) in University College Cork in order to carry out this piece of primary research. Information sheets were provided to young people and parents at recruitment stage. Both parties were also given consent forms to sign after receiving the information sheets.

As some participants were under the age of 18, an accompanying worker, from the services in which the young people were recruited from, accompanied the young people during the walking interview. The accompanying worker also received an information sheet and consent form.

Semi-structured walking interviews were conducted. According to Kinney (2017, p. 1):

"A walking interview is when the researcher walks alongside the participant during an interview in a given location"



Evans and Jones (2011, p. 850) - Figure 1.1

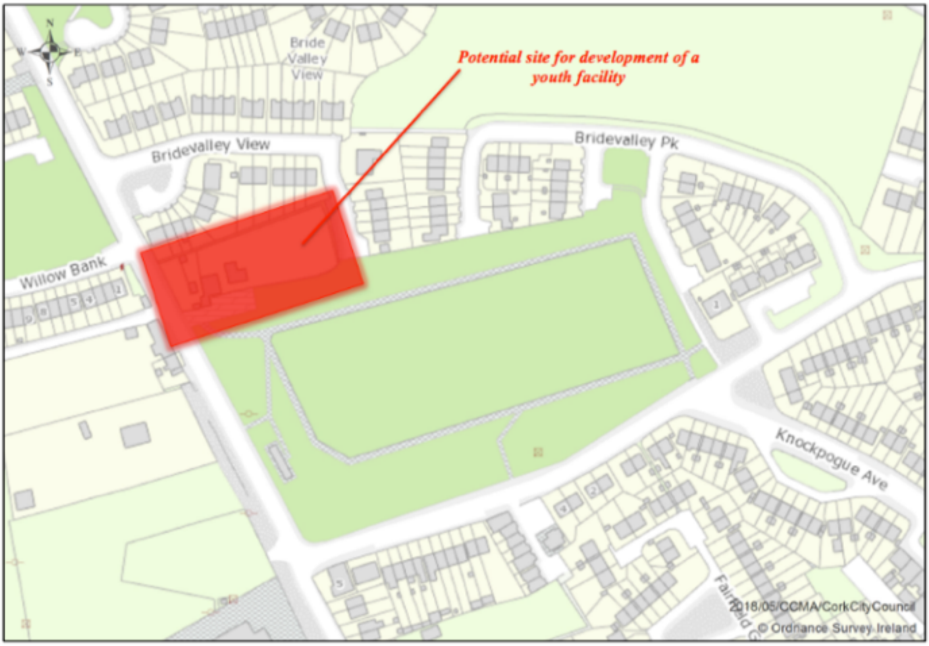
Walking interviews can be conducted in a number of ways depending on what the aims and objectives of the research are. Evans and Jones (2011, p. 850) provide a 'typology of walking interviews' which illustrates a variety of different ways of in which such interviews can be carried out (Figure 1.1).

The walking interviews in this research comprised of a partially determined route and consisted of twelve questions divided into two parts.

<u>Part one</u> acted as a scoping exercise of facilities/ services/ activities that are available/ unavailable in the area. It also explored the needs of young people in their community, issues affecting them and how they spend their free time. Participants determined what route to take during part one of the interview.

Towards the end of the interview participants had identified a number of facilities/ activities/ services that they felt the community needed in order to meet the needs of young people in the area. The young people identified spaces around the community that they felt would be suitable to build their proposed ideas.

<u>Part two</u> of the interview consisted of the researcher bringing participants to a potential site for development. This added a unique dimension to the walking interview. The young people essentially became architects of their own service through visualising and describing how they would utilise the space to cater for young people's needs.



Ordnance Survey Ireland (2018) - Figure 1.2

The walking interview acted as a mapping exercise. By taking what Bronfenbrenner (1979) refers to as an ‘ecological systems approach’ (ie. the interaction between an individual and their environment); the researcher and the participant interacted with the environment during the interview.

During the walking interviews the researcher and participants came across what Evans and Jones (2011, p.849) refer to as ‘speech objects’. In other words, objects that evoke a spontaneous discussion. Conversations arose which may not have necessarily arisen in a sedentary interview. For example, during one interview, the researcher and participant came across a burnt-out car which sparked a conversation about joyriding in the area.

Walking interviews proved to be a preferred methodology as opposed to sedentary interviews for a variety of reasons (Kinney, 2017, p.1-4). According to Kinney (2017, p.3) this method is believed to reduce potential power imbalances that could arise during an interview process:

> *“Walking alongside a participant is regarded as an inclusive process compared with the traditional sit down interview because it is viewed more as a partnership, thus reducing power imbalances.”*

Trell and Van Hoven (2010) also advise that it enables participants to be more comfortable if an interview is conducted in a setting in which they are familiar with. This is also the case in this research as interviews were conducted with participants within their own community. Reduced eye contact also increases comfort compared to that of a sedentary interview which would generally be conducted face-to-face (Kinney, 2017, p. 1-4). This can be quite intimidating and so the action of walking and talking can be less invasive.

By speaking with the young people and allowing them to be the tour guides, the researcher was able to gain both a verbal and visual insight into the lives of the youth population in Fairhill.

Walking interviews gave the young people an opportunity to tell their story in a more meaningful way by bringing the researcher to signicant places and spaces around the community. For example, participants brought the researcher to places where a lot of anti-social behaviour occurs, where illegal dumping was taking place and where they like to hang out with their friends, facilities that are and are not being used etc. The data gathered from the interviews was thematically analysed. The quotes from particpants were analysed using interpretivism.

Findings

There were a number of key findings that emerged from the research. This paper will explore a selection of the most significant findings. The quotes from participants are written in how they spoke to the researcher.

Following numerous conversations with participants, the young people identified issues that affect them as follows:

1. A lack of things to do in their community.
2. Limited opportunities for young people.
3. Young people lack a voice in their community.
4. They are rarely involved in decision-making.
5. Adversely impacted by the 'disadvantaged' label.
6. Little community development targeted for young people in their community.

1. A lack of things to do in their community
Firstly, young people expressed that anti-social behaviour (such as joyriding, vandalism, under-age drinking and substance misuse) were prevalent amongst some of the youth population in Fairhill. Participants noted that there is a lack of things to do in the area. While there are a small number of services/ activities/ facilities for young people in Fairhill, participants noted that those are not able to cater for the majority of the youth population due to space. They felt that the community house is too small to cater for large groups of young people. Participants identified a strong correlation between nothing to do/nowhere to go and anti-social behaviour and juvenile crime in the area. One participant stated:

"…there isnt a lot for young people to do around here so people have to find other ways of…... entertaining themselves (joyriding)" – Participant.

Participants felt that due to a lack of services/ facilities/ activities for the youth, young people were more likely to become involved in anti-social behaviour.

2. Limited opportunities for young people
Secondly, participants said that anti-social behaviour was also occurring as a result of limited opportunities for young people.

Participants felt that young people's potential was not being harnessed. For example, several participants suggested that there should be opportunities for those engaging in joyriding to do mechanic workshops to harness their potential in a more pro-social way:

“or even eh… mechanic workshops around here. There is nothing like for young people to do. Like I know a lot of young fellas who rob the bikes and stuff… the only reason they do it is cuz they know how a bike works… Like they’re extrememely interested in vechicles, like all of them have their own personal bikes whether they be like 12/13, … so if they’re given a way to harness that and put it to good use they’d be flying, they’d be kept out of trouble. They’d know how to work a bike. They’d know how to fix it and they could progress from there like” – Participant.

Another participant made reference to juvenile crime as a pathway for some young people whose talents are not harnessed in a pro-social way when they are young:

“It’s a disgrace to see how little they’re cared for cuz they have such good talent from such a young age. Like, they’re working on bikes since they’re like 6 or 7 and they have nothing else to do with that and when they grow up then they’re either in and out of prison cuz they have nothing else to do” – Participant.

3. Young people lack a voice in their community

Thirdly, participants felt that the young people of Fairhill were rarely given opportunities to voice their views and opinions. Participants felt that young people in their area are seldom approached or listened to regarding community development and issues that affect them.

Participants believe that giving young people a voice in their community would tackle issues of anti-social behaviour and increase better service provision. They said that if young people were consulted more in their community that services would be more tailored to their needs and as a result, would be used more frequently and effectively. The literature also suggests that youth participation for youth service planning and development is cost effective and improves service provision (Farthing, 2012, p.71-97).

4. They are rarely involved in decision-making

The findings stressed that young people should be at the pinnacle of decision-making concerning them. One participant claimed:

“It’s pointless having older men in suits doing the job when they don’t know what the young people need …cuz if they’re to do it, they’re gonna get something wrong and we’re gonna be like .. we don’t want that and it’s not gonna be used, it’s gonna be left … abandoned. So get the word of young people, get their advice, talk to them … Otherwise you’re not doing it right!” – Participant.

Young people are the experts in their own lives and their opinions should be respected and listened to as one participant mentioned:

“Young people… they know what they’re into… they know what they like, they know where they want to be.” – Participant.

Having interviewed the participants, it was evident that they were passionate about changing their community. However, there are limited opportunities for them to become involved in community decision-making. All participants expressed interest in getting involved in community decision-making if they had the chance to get involved.

A number of suggestions were made in relation to how this could be carried out. For example, one participant suggested a member of the City Council to speak to young people in the area. Another suggestion was to approach schools and conduct further participatory research with young people. Participants also felt that a youth forum should be set up in their community similar to that of the Public Participation Network (PPN) but youth targeted. Participants also felt that young people should be part of the youth facility working group.

5. Subject to the 'disadvantaged' label

Another key finding that emerged from the interviews was the meaning behind the label of being 'disadvantaged'. Participants shared how Fairhill being deemed as a 'disadvantaged' community can create obstacles for opportunities outside of their community e.g. applying for a job. One participant asserted:

"…we don't have places to go, things to do. Yeah, we're disadvantaged in that sense but otherwise it's like anywhere else... we are a community. We do need certain things to help us along our way but otherwise it's pointless calling us disadvantaged cuz we're really not like…." – Participant.

The participant continued to say how the label of being disadvantaged affects him and his peers:

"I don't like the fact that we're called disadvantaged cuz like I know fellas like when they go to places and they're asking for a job and they're like "oh! you're from Fairhill, you're … disadvantaged.. you probably wont get this job"….. but we're not just cuz we come from certain locations, doesn't mean we are any different from anyone else and it annoys me then like the fact that just cuz the place has a bad reputation we got that name over being disadvantaged, we're not!" – Participant.

This powerful quote highlights the negative connotations that accompany such a label and echoes the effect of the environment on the individual. In this case, coming from a 'disadvantaged' background creates barriers and obstacles to opportunities and young people's future. Participants felt that the key to breaking down such barriers was to develop the area by the introduction of facilities/ activities/ services and to provide ample opportunities for people in areas such as schooling, employment etc.

6. Little community development targeted for young people in their community

The quote above also reiterates the need for community development as a way of breaking down barriers created by this label. It also echoes the need to draw on the transformational goals and national outcomes set out in Ireland's 'Better Outcomes Brighter Futures strategy 2014-2020' (Dcya, 2014).

Another participant made reference to intergenerational patterns, stressing the importance of change in the community for the benefit of the younger generations:

"You can see it straight away, like the younger generations below me, they're already starting… My generation is extremely bad and the generation below me is getting worse and I don't think it will ever change unless we force it to change! That's my biggest problem like eh… the area has to change whether we like it or not and I hope it changes for the better. Otherwise, nobody will ever take Faranree, Fairhill, Churchfield, Knocknaheeny seriously again" – Particpant.

Young People and Decision-Making

Youth participation was a key underpinning of this research. Having conducted the walking interviews and obtaining some of the youth voices from the community, it is evident that young people are indeed cogent and articulate about their lived environment. Participants went into great detail about ways the community can meet the needs of the youth in Fairhill making some very strong arguments and key points.

As Dr. James Reilly (Acted as former Minister for Children and Youth Affairs) claimed that society rarely regards contributions made by children and young people as valuable (DCYA, 2015, p. v). However, according to Dr. Reilly this should not be the case. He stressed the importance of youth contributions by stating;

"… young people are not 'beings in becoming', but rather are 'citizens of today' with the right to be respected and heard during childhood, their teenage years and in their transition to adulthood" (DCYA, 2015, p. v).

Talking with the participants showed the power of youth participation and the potential it brings for meaningful effective change to youth and the wider community. In order to do this though, their involvement is key, which is why the social professions should advocate in favour of this in practice.

Relevance to social work practice

The findings from this research are very relevant to social work practice. They raise key messages that professionals should consider in practice.

1. The effect of the environment on the individual

This research placed a strong focus on the environment and how it can address the needs of young people or hinder them from being met. As social workers, we draw on resources within the community to create support networks around people. Without key services/ facilities/ activities/ resources, how can social workers create meaningful change in a sea of limited resources?

Should social work; collectively as a profession, encourage community development where necessary so that stronger support systems are put in place for service users?

It is not enough for practitioners to be person-centred in their approach to casework. Adopting an ecological systems approach by recognising the importance of the environment and its effect on individuals is another necessary step in assessments. It is vital to identify the needs of individuals. However, when those needs are prevalent amongst several people in the community then professionals should adopt a wider lens.

This could develop if social workers; that perhaps are on the same team or are covering the same geographical area, recognise similar patterns and issues arising for service users. In turn, finding ways of addressing these by introducing new programmes, services, and activities for young people to address any issues identified. This could lead to another way of looking at practice.

For example, Joyriding has been prevalent in the north side of Cork City for generations, resulting in a number of tragic deaths of young people (Hogan, 1997; Mooney, 1999, Reigel, 2004). Social workers and youth probation officers who work with young people engaging in this behaviour can explore; along with the young people themselves, what needs to be introduced into the area in order to minimise the issue of joyriding.

Participants in this research suggested mechanic and motorcycle workshops as a more pro-active way of being around vehicles. Participants also felt that this could harness the potential of many young boys in the area and could potentially lead to future employment as a mechanic.

The impact of one's environment does not just apply to communities that are deemed to be 'disadvantaged' but also to communities that are considered to be quite 'affluent'. As outlined in the recent Douglas Matters CARL project (Daunt, McCarthy and Tipps, 2018), similar issues arose for young people in Douglas to that of the young people in Fairhill i.e. a lack of things to do or places to hang out for young people in their community.

2. Micro/macro lens of working with service users: recognising wider community issues that affect individuals

The profession should adopt both a micro and macro lens of working with service users in order to recognise wider community issues that affect individuals. In this research participants spoke about issues such as anti-social behaviour in the form of joyriding, illegal dumping and fires. These are issues that affect the community as a whole. If social workers advocated for activities; e.g. the mechanic/motorcycle workshops mentioned previously to be introduced into communities, it could minimise intergenerational patterns such as joyriding in Fairhill and could veer young people away from anti-social behaviour, thus minimising juvenile crime.

3. Implementing policy more into practice through creative methods of obtaining service users' voices

There appears to be copious amounts of literature on youth participation in Ireland. After all, the country has its own youth participation strategy (DCYA, 2014). However, in practice youth participation appears to be seldom, particularly in areas such as community development and decision-making that is youth targeted. In this research when participants were asked if they were ever involved in community decision-making or ever consulted about anything in their community, all participants stated that they were never consulted and they also said that they were not aware of their peers being consulted.

Participants in this research felt that facilities introduced into their area were not as effective as they potentially could have been because young people's views were never obtained. One participant gave the example of an outdoor gym, which they felt was not used. This participant advised that young people would use the gym more if it were more sheltered as the area is very exposed and also if it were a larger space.

4. Service users as 'architects' of their own service to encourage better service provision

As stated earlier, the methodology used in this research added another layer to data collection. Participants became 'architects' when brought to the potential site for development. The young people both verbally and visually described how they would utilise the space in front of them and what they felt would be most widely used by their peers. Participants went into great detail regarding this, from the number of floors the building would consist of, to the types of activities and groups that would be run there.

Participants voiced what they consider young people need in Fairhill. Without these suggestions it is only a mere guessing game amongst adult stakeholders, which is why young people's involvement is crucial in community development and decision-making.

This research was creative in its methodological approach. The element of walking and talking added multiple dimensions to obtaining youth voices. It is clear that social workers, as practitioners and as a profession should encourage and introduce more creative ways of obtaining youth voices.

Feedback is a vital aspect of community-based participatory research. According to Israel et al. (1998, p. 173-202):

"community-based research seeks to disseminate findings and knowledge gained to all partners involved".

Having shared the findings to the youth facility working group post data collection, many members were both impressed and surprised by some of the suggestions posed, as they had not considered such points themselves.

Participants also discussed what wouldn't work for them and their peers. This information was invaluable. Now, the working group can proceed knowing that by taking the participants' suggestions on board, anything that will be introduced into the area will try to be as close as possible to the suggestions made by the young people, essentially providing more effective service provision. As well as this, they aim to get a number of young people to become members of the working group.

It should be part of practice that with every service/ programme/ facility/ activity that is introduced into any community, the service users, whose use it is intended for, should always be consulted. Tokenism as well as Arnstein's (1996, p. 216-224) 'ladder of citizen participation' and a democratic approach could be useful tools to draw on to ensure that power is shared amongst all relevant parties when it comes to community involvement in policy, planning and development.

Gaining service user's opinions, not just that of young people but service users of all ages, when considering any form of community or service development is key for effective use of funding and resources. It also ensures that such developments meet the needs it intended to from the outset.

5. The importance of community-based participatory research (CARL) in Social Work

Community - based participatory research is very significant to communities who require development. In this case, Fairhill were aware that young people's needs were not being met. By carrying out research, some of the youth voices of Fairhill were obtained. Participants discussed how they felt young people's needs could be addressed in the community. CARL creates a bridge between universities and communities so that students can carry out research for college requirements that in turn benefit communities who do not have access to large databases and ethical screening unlike the students who carry out the research.

This research has opened more doors for enquiry and the community will continue its relationship with CARL students to obtain further research to benefit the Fairhill community.

The findings of this research will also be used as part of lobbying and funding for services and community development in the area. Fairhill has sourced a potential site for development of a youth facility, which in this research all participants identified as an ideal location. Following this research, the working group now has findings to support this development, which they have presented to Cork City Council alongside the statistics from the Cork City Profile (Healthy Cities 2014; 2018) in the hopes that the Council will support such development.

Conclusion

This research demonstrates how social work must look at practice from many lenses, considering the role of the environment and seek ways to address wider community issues. Social workers need to find more creative ways of obtaining youth voices in daily practice and communities that they work with. The research not only highlights the value of youth voices but also the voices of all types of service users and how their word could lead to better service provision.

The research demonstrates how service user voices can lead to positive, impactful community development. This involves teams of social workers coming together with other professionals, communities and the young people themselves to start a conversation that will lead to potential for preventative work and bettering communities.

Young people may be young but that does not mean that they are not aware of issues that affect them and that they do not possess the ability to articulate their views or be part of decision-making. Young people's voices need to be heard and the social work profession should continue to transfer this, as advised in theory, into practice. Social work needs to listen to and meet the needs of the young people of today who are the adults of tomorrow.

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SOCIAL WORK – FACILITATING CONNECTIONS, INTEGRATING CARE

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Abstract

Integrated care is a complex subject which is difficult to define and even more difficult to implement. Regardless of definition, key to the success of any attempts to integrate care are good relationships, collaboration, clear communication and cooperation. This paper reviews the concept of integrated care, within the context of older persons services in Ireland, and considers social work's key role in the move towards an integrated health and social care system. The skills required and principles and aims of integrated care are not new to social work. While the new integrated care agenda may pose some challenges for social work across all sectors, social workers' varied training, knowledge, value base and skill set posit them as "uniquely qualified" to lead out in the process (Cooper, 2017), and reframe these challenges as opportunities for the profession to progress. In demonstrating an example of the social work value, the paper reviews a speed networking initiative, which this author led on, in an effort to better integrate older persons supports and services. The paper concludes by reminding readers that integrated care is everyone's business, and not just those working on integrated care teams. Social work can become central catalysts in the process and support colleagues across all sectors in adjusting to the changes required to provide better integrated care to older persons and their families.

Keywords

Integrated Health and Social Care. Integration. Synergy. Holistic. Fragmented Systems. Social Work. Systems. Interpersonal Relationships. Collaboration. Cooperation. Communication. Coordination. Case Management. Speed Networking. Co-production. Service User Involvement. Capacity Building. Older Persons. Gerontology.

Introduction

"Integrated care is a journey not a destination. We cannot fix the health system by strengthening the silos. More connections should be encouraged" (Dr Ronan Fawsitt & Dr Garry Courtney - Houses of the Oireachtas, 2017: 69).

Integrated care will require key professionals across all levels to facilitate and lead the change management process (WHO, 2013). In reviewing the profession's ethos, skillset and training, this article considers social work's potential role in advancing the integrated care agenda. While this paper's focus is specifically on integrated care in the context of older person's services, the material discussed will be of relevance to social workers across all sectors. Can social work's interpersonal skills and holistic systems focus, as used daily in casework, be adapted to engage colleagues to embrace the changes required and work collaboratively in an integrated manner? How does the social work ethos fit with integrated care? What other social work skills and approaches might be of benefit in efforts to coordinate services and support older persons to live well at home? The author's reflections on their experience of initiating and leading on an integrated care project further demonstrates the potential value of social work. The move towards integrated care presents challenges for social work. However, the paper posits that it also provides a significant opportunity, if the profession choses to embrace it.

The Context and Rationale for Integrated Care of Older Persons Services

In Ireland there is a change in the profile of the population (ICPOP, 2016; Department of Health, 2015). Those aged 65, and over, comprise 12.7% of the population and use 53% of inpatient beds; with this age group's population projected to increase by 107,600 people (17.3%) by 2021. Up to 40% of those waiting more than 24 hours in ED are over the age of 75. Over 75s spend three times longer in emergency departments than those aged 65 or less and are three times more likely to be readmitted within 30 days of discharge.

The risks of hospitalisation for older persons are well known. These include iatrogenic complications such as falls, delirium, medication interactions and infection. Sager et al.'s (1996) research also evidences a significant risk of functional decline with a 30% decline in PADLs on discharge and 40% decline in IADL ability three months post discharge. Fifty per cent of acute hospital delayed discharges require the nursing home support scheme or a home care package. Furthermore, over 4% of the population provide informal unpaid care with the age profile of carers increasing (39% increase in carers age over 75 years) (Department of Health, 2015).

Care systems throughout the world are 'failing to cope' with such changing demographics (Goodwin, 2016). The complexity of health systems' design often leads to a lack of 'ownership' of the service users' problem (Goodwin, 2016). Treating one condition without recognising others leads to segmented care, poor communication within and between services, duplication and gaps in care provided. This frequently results in poor outcomes for the person and for the system as a whole (Goodwin, 2016). Integrated care is proposed as a solution to these issues. But what is integrated care?

Defining Integrated Care

How often have you asked 'John' the same assessment questions that his public health nurse asked him yesterday? How timely is your communication with the hospital when 'Joe' is admitted? Have you ever considered sharing your assessment and closure summary with

‘Mary’, and all services involved in her care? How often have you spoken with ‘Ann’s’ PHN during the two weeks she has been on your caseload?

In their literature review, Armitage et al (2009) highlight the lack of agreement in attempts to define integrated care, with their review identifying 175 definitions. “Integration (from the Latin integer, meaning whole or entire) generally refers to combining parts so that they work together or form a whole” (Kodner and Spreeuwenberg, 2002: 27). Integrated care seeks to address fragmentation in the system (Goodwin, 2016; Stein and Reider, 2009). In the literature the words collaboration, coordination, synergy and integration are used interchangeably when discussing integrated care.

The WHO defines integrated care as the organization, planning and management of health services so that people get the right care, at the right time, in the right place in ways that are user friendly (Gröne and Garcia-Barbero, 2002). It is a move away from unplanned, episodic care in the acute setting to care that is delivered “at the lowest level of complexity” (Houses of the Oireachtas, 2017: 73), i.e. at home where possible. It is care that is preventative, person centred, empowering, planned, anticipatory, well-coordinated, continuous, efficient and evaluated against user needs as improving quality of life and outcomes for both the user and the system (Houses of the Oireachtas, 2017; ICPOP, 2016; Department of Health, 2012). Both individual care and services are designed with, rather than for the person (ICPOP, 2016).

Users want continuity of care (Waddington and Egger, 2008). “Integrated Care aims to join up our health and social care services” (ICPOP, 2015: 1). Timely communication and information sharing to support positive decision-making, good governance and accountability is key (Houses of the Oireachtas, 2017: 73). The experience for the user is holistic care that is seamless, smooth and easy to navigate (Waddington and Egger, 2008), across acute and community, primary and secondary, statutory and voluntary, private and public sectors. This coordinated approach eliminates the person having to repeat their story unnecessarily and ultimately should also minimize both the number of stages in an appointment and the number of separate visits required to a health facility for that user (Waddington and Egger, 2008). To the worker, this means changing the way that care is provided (ICP News, 2015: 1). It means “working with professionals from different fields and coordinating tasks and services across traditional boundaries” (Darker, 2014: 26), while putting the service user at the centre of care planning and service design.

This is quite aspirational. But how can it be achieved in reality?

There are many ways to implement integrated care, each with its own complexities. Integrated care can occur at the macro policy planning level, at organisational and service provision level and/or at individual professional level (Goodwin, 2016, Pike and Mongan, 2014; Darker, 2014; Ham and Curry, 2011). It can vary from informal linkages to more managed, formal care co-ordination across services and systems (Goodwin, 2016: 2). Its focus can be on the whole population or a specific client group, such as older persons, as determined by population needs.

Fundamentally, and for the purposes of this paper, “there are two levels of integration:

the structural, which refers to health care systems and clinical, which refers to how providers work with each other" (Stanhope and Straussner, 2018: 377-388). Evidence indicates that organisational or structural integration will not deliver the desired outcomes if clinicians do not change how they work. Organisational integration is not necessarily required. The key requirement is clinical, professional and service level integration (Houses of the Oireachtas, 2017: 73), i.e. coordination, collaboration and communication between and across disciplines, services and sectors (Goodwin, 2016), with the user at the centre of care planning and service design (Department of Health, 2012: 16). "An alternative to organisational integration is to find ways of enabling organisations to co-ordinate their work more effectively…The challenge will be to support the development of networks between these organisations" (Ham and Curry, 2011: 2).

It is here, at the clinical and service user involvement level that perhaps social work can have most impact (Stanhope and Straussner, 2018: 377-388). So, what is it that differentiates social work as potential distinct leaders in advancing the integrated care agenda?

Social Work is Integrated Care

Many authors and presenters speak of integrated care involving 'different' values and a 'new mindset' or 'new ways of working' referencing a move away from the paternalistic, hierarchical, disease model to a focus on the social, the 'whole' person and person centred, co-production and case management (ICPOP, 2016). Minkman (2016) speaks of the values and principles of integrated care, referencing terms such as equity and access, empowerment and respect, rights and responsibilities, coordinated and holistic, collaboration and co-production.

This approach is not new to social work. "Social workers know about these concepts through their daily work" (Phillips, 2016). Social work's ethical and value base (See Biestek, 1961; Thompson and Thompson 2008; Banks, 2012) has its roots in an "empowering", holistic model of working with people (Godden, 2016: 4). Social work's theories, methods and approaches to practice (Healy, 2014; Healy 2012; Moore, 1990) posit them as skilled at assessment, case management and care coordination in partnership with users, their family and other services. It is a profession at ease with managing and containing risk, uncertainty and complexity.

The social model of care, with a focus on a person's rights to self-determination, highlighting ability, strengths and solutions, offers a valuable compliment to the traditional medical model approach, focused on 'disease' and the professional as the expert. Through such practices, social workers support the user and their families to see diagnosis as only one aspect of their life identity (Cooper, 2017; Straussner; 2018), an approach less developed in health (Godden, 2016). This problem solving and risk enabling approach offers a healthy challenge within systems, and in decision-making (Cooper, 2017), and can support the move towards a focus on service users and communities as expert.

Founded on community engagement, with groupwork and community development essential interventions in our practice (Romeo, 2017; Payne 2005), social work has pioneered inclusive practices and co-production at both individual and wider system level. Here within presents further opportunity for social work to demonstrate their value by supporting other health professionals to engage with service users and community groups to address need. Social work's ability to mobilise resources, collaborating with users and providers across the system, often leads to cost-effective interventions, programmes and groups that focus on prevention and wellness management - key components of integrated health and social care (Straussner, 2018). Their groupwork and facilitation training also provide social workers with a unique skillset in striving towards participation at all levels from consultation to full control (Arnstein, 1969).

Social work training also provides us with a skillset which may be invaluable in supporting colleagues to embrace the changes required to enable integrated care. Regardless of definition or level, collaborative working, cooperation, relationships and good communication within and across the various parts of the system are crucial if more person centred, coordinated, integrated care is to be successful (Valentijn et al, 2013; Cameron et al, 2012; Kodner and Spreeuwenberg, 2002; Walsh 2013). These skills are all integral to social work training and practice.

Integration is at the heart of systems theory. It is the 'glue' that binds the different components of a system together enabling it to achieve shared goals (Kodner & Spreeuwenberg, 2002). Integrated care is preventative in tackling the social determinants of health and led by whole systems thinking (Minkman, 2016). Integrated care involves adopting a holistic approach, working across traditional boundaries (ICPOP, 2016). Such premises are at the core of social work practice. Social work training is founded on systems theory and the socio ecological model of holistic care (Stanhope and Straussner, 2018: 377-388; Jacob, 2013). "By working within the framework of the determinants of health, social workers make the necessary links between physical, social, emotional and economic impacts on health" (IFSW, 2008). "Social workers are trained to be connectors and translators, communicating across cultures and systems" (Cooper, 2017).

Rooted in the tradition of relationships (Godden, 2016:3; Straussner, 2018), the interpersonal relationship is 'the starting point in how social workers deliver care' (Cooper, 2017). Their professional and relational skills facilitate a team around the person to ensure effective and coordinated responses to need (Cooper, 2017). Social work's skills in advocacy and navigating through systems (Jacob, 2013) assists service users and colleagues to break down bureaucratic and traditional barriers (Cooper 2017; Ripfa 2015) and facilitates connections to non-medical resources that impact a person's health (Stanhope and Straussner, 2018: 3-20; de Saxe Zerden, 2019). Such ability to work with a wide range of agencies, ranging from health, finance, community, employment, housing and education supports, works to address all components of a person's situation (Godden, 2016), and is essential to good case management and care coordination. These skills are also vital in building the trust and cross agency team approaches required to facilitate good integrated care.

As systems and relationship specialists, social workers have a unique ability to engage individuals, groups, communities and organisations to promote systemic understanding and sustainable systemic change (Jacob, 2013: 3; Healy, 2005). Social workers are adept at "facilitating communication in complex situations" and understanding how systems work to enable them to lead in coordinating diverse groups of professionals and providers, focused on the care of the user (Godden, 2016: 18). The profession's focus on building and maintaining healthy relationships while communicating and advocating enables them to “slice through the intractability of inter-agency working” (Godden, 2016: 18), and indeed of multidisciplinary team working, to ensure integrated service provision at all levels (Jacob, 2013: 195). Going beyond the profession's collaborative, relationship building and inter agency, Lyn Romeo (2017) highlights social work's ability to facilitate, mediate and manage team conflict as positing us as key to integrated care. Given the need for services to realign their values, approaches and practices (and agree same across traditional service and sector boundaries) to progress the integrated care agenda, these skills will be critical.

Integrated Care is not without its Challenges

While it is obvious that the social work profession has much to offer in terms of knowledge, skills and experience to the integrated care agenda, the move towards integrated care also poses some challenges for social work and for organisations and multidisciplinary teams as a whole. As with all cross-agency collaboration, contextual, institutional and professional factors influence how positive or negative the environment is for integrated care. Reviewing a range of studies, Auschra (2018) identifies twenty types of inter-related barriers to integrated care, while Ling et al. (2012) speak about these barriers under the following headings:

- Information Technology,
- Relationships and Communication,
- Professional engagement and leadership, credibility, and shared values
- Organisational Culture and History and
- The Extent of integration.

Due to the limits and scope of this article, this next section will highlight some key challenges observed by the author as facing the social work profession specifically.

At Policy Level - Social Work Recruitment

Social work has long been a forgotten piece of the jigsaw when recruiting for multidisciplinary teams, particularly when it comes to community social work posts, with other more HSCPs and nursing posts taking priority. The dearth of social work representation and slow recruitment of social workers in both primary and integrated care in Ireland are examples of this. Social workers have been making significant contributions to integrated health and social care prior to this new movement. It is time that their contributions to individuals and their families, to other health care professions, and to society are fully recognized (Straussner, 2018). As a profession, social work must embrace the opportunity that integrated care presents for social work across all settings to showcase its value and its evidence it' contribution to the integrated care agenda, as set out in Slainte Care (2017). The author posits that the move towards integrated care poses a real opportunity for the social work profession in Ireland to become pioneers and act as change agents to facilitate others to embrace the changes required to enable integrated care. In modelling collaborative working and facilitating others to adopt an integrated care focus, social workers can demonstrate their value.

Professional Identity

But first, social work must be clear about its role and professional identity. Integrated care requests that staff collaborate and work together. In order to do so, workers need to have a basic understanding of each other's roles. Often other disciplines have no idea about the work of social workers, or the ethics, values and code of practice within which social workers operate. "The social work contribution must be clear, captured, and communicated so that there is a good understanding of its necessity: this should be across all levels from practice to strategy" (Cooper, 2017:10). This clarity will also go some way in protecting the social work role and identity with the move towards integration and interdisciplinary working (Godden, 2016). It will also assist in demonstrating the social work impact.

Measuring the Social Work Impact

Many skills regularly used by social workers provide intrinsic, indirect value that is hard to measure (e.g. addressing the determinants of health) and renders the return on investment of the work of social workers difficult to measure (Lombardi, 2017). The profession needs to become better at measuring the impact of its work, evidencing same through research, utilising service user feedback and outcome measures to quantify how social work improves the quality of people's lives, and contributes to better coordinated, efficient and effective service delivery.

At Management Level

Social work management must support their social workers to operate in an integrated manner; modelling collaborative behaviours and empowering their staff to demonstrate the professions integrative approaches and skills at individual, group, community and wider system level. "Senior managers with a social background can ensure a strong social work value base is integrated into arrangements, and a focus on what matters to people" (Cooper, 2017: 10).

Education and Training Needs

Social work educational programmes need to include integrated care as a module to ensure social workers are equipped to understand the various, complex models of integrated care deployed in practice and are better able to demonstrate the social work value in practice (De Saxe Zerden et al, 2018). Social workers in training institutions, practice settings and social work associations can also lead out in initiating *joint interdisciplinary training for all disciplines* to foster a better understanding of roles and shared approaches to concepts such as co-production, case management and risk management.

Despite these challenges, social workers at individual and service level can utilise their skills, training and experience to advance integrated care in their local work settings. A key challenge for social work is to decide if, as a profession, it wishes to be a leader in integrated care. The following is one example of an integrated care project that this author led on, employing the social work skills, knowledge, approaches and values discussed earlier.

A Social Work Initiative: 'Integrating' Care

Providers

Any attempt to integrate care must involve *"network building between public, private, voluntary, health and social care providers and advocacy groups"* (Houses of the Oireachtas, 2017: 74).

Working across hospital and community, the author observed that individuals working in the various health and social care settings were not familiar with each other's roles or services. Similarly, local community groups and older persons reported they did not know who was who in terms of health services, or how to access supports to address their needs. This was also reflected in feedback by over 60 attendees at a Listening to Older Persons Workshop facilitated in the area in early 2018 by ICPOP, Age Friendly Ireland and the Dublin North Integrated Care Team. The author observed that this fragmentation was leading to inefficiencies in communication, timeliness of information sharing and intervention. It also resulted in gaps in service delivery yet duplication of tasks across services. There was a lack of trust, collaboration and shared ownership between services and sectors.

Addressing the Need

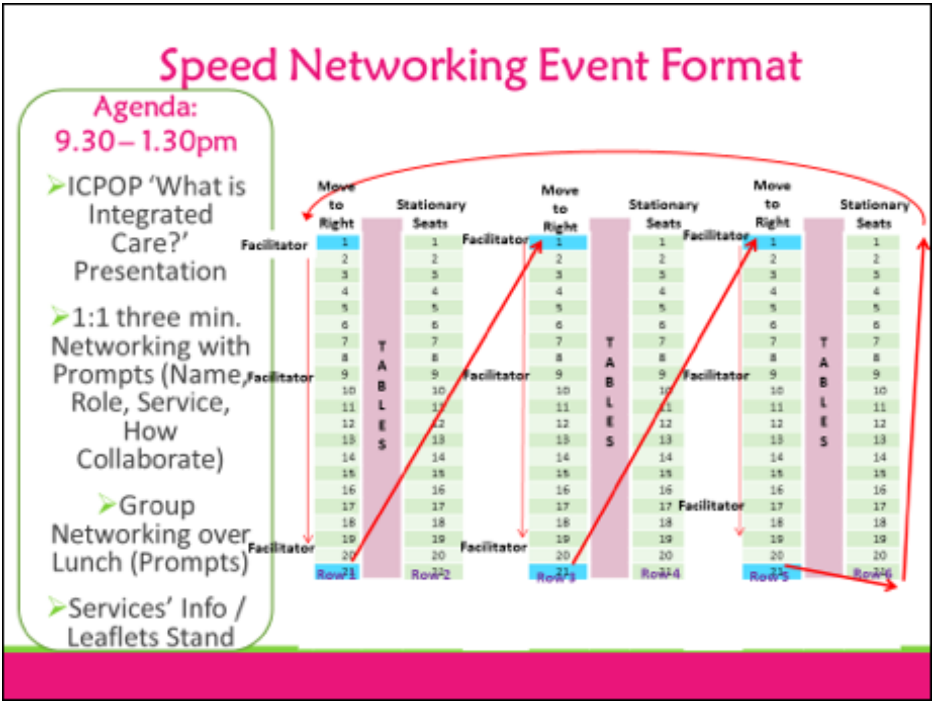
The author proposed a speed networking event to address the issues observed. Social work's problem solving, advocacy, interpersonal and communication skills were used to engage senior HSE management, Beaumont Hospital, the national Integrated Care for Older Persons Programme and the local Age Friendly Alliance to support the proposal. Funding was obtained from the latter with the health service bearing no financial cost, aside from the author's time in planning and preparing for the event and attendees' time on the day.

Social work established a cross sectoral, multidisciplinary, planning group, which included a service user representative. The methodology employed was a PDSA Cycle (Deming, 1993; Deming; 1986). In September 2018, this social worker facilitated a Speed Networking Event for all services and groups working with over 65s. The event targeted service providers working across the acute, community, hospital and voluntary sector. A social determinants of health approach (Dahlgren and Whitehead, 1991) was employed in considering services and groups to invite.

The aims of the event were to facilitate participants to: build relationships, improve communication and referral pathways across acute, community, statutory & voluntary, health and social care services and sectors; to better understand integrated care and ultimately, empower attendees to empower older persons & carers through social prescribing. It was hoped that this would in turn foster the integration process, lead to more efficient and timely referral pathways and improve services' ability to empower service users with information about supports available.

Speed Networking on the Day

Social work facilitated one to one speed networking for three minutes where attendees rotated, explained their role and the role of their service with older persons and how they access same (see image to follow). Prompts were provided on a PowerPoint slide to aid conversation flow and rotation was facilitated. A presentation on integrated care, service's information leaflet stands and group networking over lunch were also aspects of the day.



Speed Networking Event Format

Agenda:
9.30 – 1.30pm

- ICPOP 'What is Integrated Care?' Presentation
- 1:1 three min. Networking with Prompts (Name, Role, Service, How Collaborate)
- Group Networking over Lunch (Prompts)
- Services' Info / Leaflets Stand

The total number of participants who signed up were 122, while 107 attended on the day. Ninety-seven evaluations were complete, providing feedback on the planning, execution, objectives and outcome of the event.


Who was in the room?
A Social Determinants Approach to Health

Total Attendees:

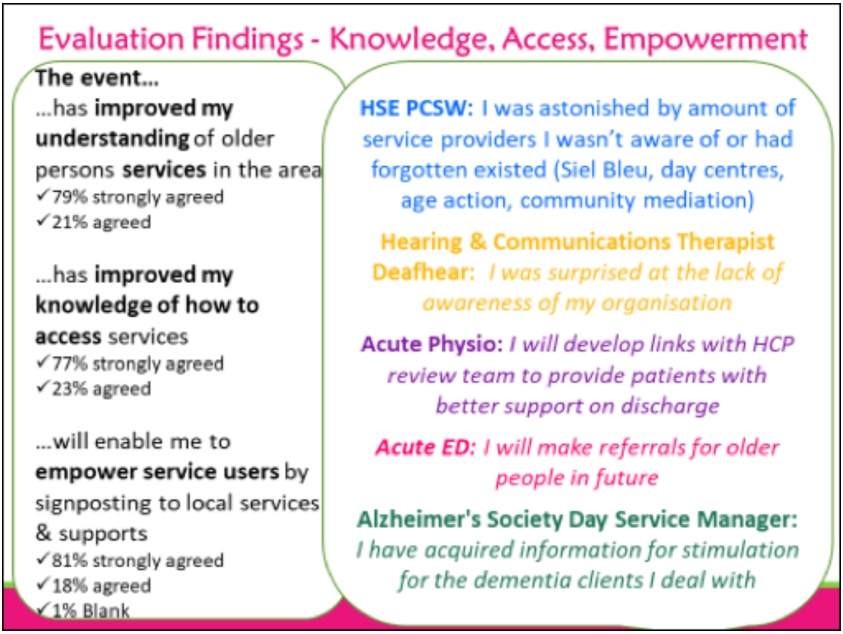
122 Signed Up

107 Attended

97 Evaluations

Did the event achieve its aims?

Ninety-seven evaluations were complete, providing feedback on the planning, execution, objectives and outcome of the event. Responses to the feedback evaluation were consistently positive across all domains.



Evaluation Findings - Knowledge, Access, Empowerment

The event…

…has **improved my understanding** of older persons **services** in the area
✓79% strongly agreed
✓21% agreed

…has **improved my knowledge of how to access** services
✓77% strongly agreed
✓23% agreed

…will enable me to **empower service users** by signposting to local services & supports
✓81% strongly agreed
✓18% agreed
✓1% Blank

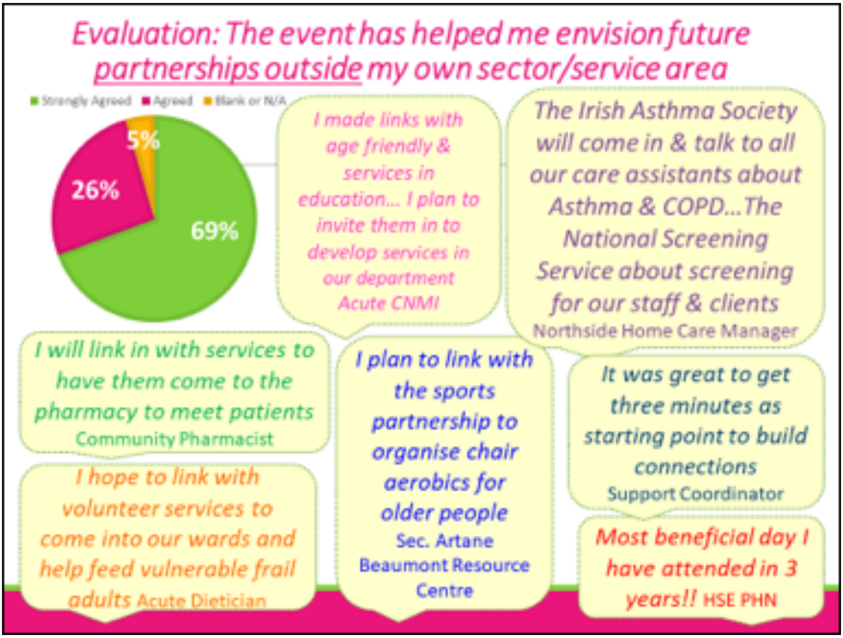
HSE PCSW: I was astonished by amount of service providers I wasn't aware of or had forgotten existed (Siel Bleu, day centres, age action, community mediation)

Hearing & Communications Therapist Deafhear: *I was surprised at the lack of awareness of my organisation*

Acute Physio: *I will develop links with HCP review team to provide patients with better support on discharge*

Acute ED: *I will make referrals for older people in future*

Alzheimer's Society Day Service Manager: *I have acquired information for stimulation for the dementia clients I deal with*



Evaluation: The event has helped me envision future partnerships outside my own sector/service area

I made links with age friendly & services in education… I plan to invite them in to develop services in our department Acute CNMI

The Irish Asthma Society will come in & talk to all our care assistants about Asthma & COPD…The National Screening Service about screening for our staff & clients Northside Home Care Manager

I will link in with services to have them come to the pharmacy to meet patients Community Pharmacist

I plan to link with the sports partnership to organise chair aerobics for older people Sec. Artane Beaumont Resource Centre

It was great to get three minutes as starting point to build connections Support Coordinator

I hope to link with volunteer services to come into our wards and help feed vulnerable frail adults Acute Dietician

Most beneficial day I have attended in 3 years!! HSE PHN

It is also important not to assume that integration occurs within teams, wards, services or sectors. A surprising outcome was the comments regarding internal connections made:

Evaluation: The event has helped me envision future partnerships within my own sector/service area

By talking to the CNMII in X ...my patients were having unnecessary blood testing – one lot going to one hospital and second lot back to another. I hope to end this practice ... also to encourage more nurses to train in giving IVAB in nursing to cut costs for HSE
Acute CNMII

Liaise with pharmacists for better communication; liaise with community physio and FITT teams for early identification of frailty Acute cANP

I plan to meet primary care teams at monthly meetings and link further with primary care social workers
HSE Smoking Cessation Advisor

HSE Diabetes Clinical Nurse Specialist: Smoking cessation now have direct referral forms [for my service]. I will also link with community based physical activity

This initiative also demonstrated that moving towards integrated care not only benefits the service user, but also staff wellbeing. Facilitating connections across and between service providers can alleviate staff feelings of isolation and potentially prevent burnout.

"…the biggest asset of the day was feeling like I wasn't alone in my work … you can get very involved and end up feeling quite pressured ... It was a great feeling to see how many other professionals want to collaborate … working together lightens the load…and provides a wider & improved service" - HSE Social Worker

The speed networking event has been approved as a template for other networks in the CHO and endorsed by ICPOP and Age Friendly Ireland as a key enabler of integrated care. There is much focus on the dearth of resources within healthcare systems. This exercise highlights the vast array of services available within just one small region, to support older persons to live well at home.

Participants at the event consented to their details being included in a local directory of services, Services unable to attend on the day were also included in the directory, developed by the author. The directory contents were wide ranging with the following image highlighting a sample of the magnitude of third sector supports available within one small catchment area, serving a population of 13,833 older persons (CSO Census, 2016).

At an inter-agency level, the directory is being adapted into an online version to enhance ease of access and to allow for updates as required. Using this approach nationally has the potential to overcome gaps in health service resources, and support integration, in line with the ICPOP (2016) 10 Step Framework.

The Author’s Reflections on The Value of Social Work

While the author’s reflections and learning were vast, what was evident throughout the project is the different way of thinking and approach that social work contributes when overcoming barriers, engaging all stakeholders, especially service users, mobilising resources and support, and facilitating the planning and implementation of an initiative such as this. Social work maintained a focus on the service user throughout. In overcoming barriers, and harnessing drivers for change, social work employed interpersonal communication skills and a system’s approach in advocating to mobilise resources in support of the proposal. A social determinants of health approach enabled the author to identify services and groups to invite to the event. Social work’s groupwork and facilitation skills were used to facilitate the event on the day, while our community capacity building approaches assisted this social worker with supporting the service user to be fully involved throughout the event, including in post event national presentations. Social work’s solution focused attitude, motivational methods of engagement, alongside the ability to manage and contain risks, supported other professionals to overcome their fears and limits, and engage in this opportunity to connect with others. These social work skills can be used across all settings and in all interdisciplinary, cross-sector and inter-agency collaborations to facilitate the behaviour changes required of staff to embrace a move towards integrated care.

Reflections & Learning

Pre Event:

- **Feedback** Post SU Consultations
- Find Partners – Find the energy!
- **Engagement takes time! Focus on Benefits** to Attendees/Older Person
- Key Contact Person
- **Invitees: Social Determinants, Holistic, Systems Approach**
- SUI & Inter Agency Working. Pace. Balance Commitments & Relationships
- **Registration Form = Directory**
- Workplan - Assign Tasks
- **Prepare Attendees**
- Venue Set Up, Labels, Timing, Location
- **Table Plan & Be Flexible**

During Event:

- **Timekeeping & Facilitators!**
- Extra Facilitators/ Registration
- **Acoustics - Separate Tables**
- **Time of 3 Min = Speed, Energy, Enthusiasm**
- MC / Moderator/ Oversight
- **Stand for Lunch**
- **Water!**

After Event:

- **Build on Momentum!**
- Reflect & Share
- **Share Directory ASAP**
- Mailing List
- Be prepared for demand!

Conclusion

Integrated care is a complex subject which is difficult to define and even more difficult to implement. Systems and processes will need to change, but ultimately it will require a shift in behaviours, with the actions of the staff working in and with health and social care services determining whether integrated care becomes reality (Walsh, 2013). It will require leaders across disciplines to spearhead the change required. Regardless of definition, key to the success of any attempts to integrate care are good relationships, collaboration, clear communication and cooperation. The skills required and principles and aims of integrated care are not new to social work. Social workers' varied training, knowledge, value base and skill set posit them as "uniquely qualified" to lead out in the process (Cooper, 2017). As the project example above demonstrates, social work's value is not just in the profession's contribution at individual case management and coordination level, but also at the wider team, service and system level.

While the transformation will posit many challenges and implications for social work training, policy and practice, the author argues that it presents an opportunity for social work to demonstrate our varied and adaptable skills. "Social workers and GPs, working together, are best placed to coordinate the efforts of health, social care and housing in the interests of service users" (TCSW and RCGP, 2014). Ultimately, it is the responsibility of social work to decide how much it will seek to lead integrated care practice, policy and study. Social workers can be the agents of change, trailblazers at the fore of the integrated care movement… if as a profession it chooses to.

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PROMOTING FAMILY FOCUSED PRACTICES IN IRISH MENTAL HEALTH SERVICES

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Mary G Killion is employed as a Principal Social Worker in Galway/Roscommon Mental Health Services. She has been promoting Family Focused Practice in Mental Health services since 2005 when she co-ordinated an Interagency Service Initiative established to address the impact of parental mental illness on parents and families – known as Crosslinx. Mary G has established a similar service initiative in Galway/Roscommon - known as Crosslinx West – and is the Project Lead for the rollout of Family Talk in Galway/Roscommon. She completed an M Litt with Trinity College Dublin in 2013 in relation to a Case Study of professionals' involvement in a Family Focused Practice. She has previously worked in CAMHS, Early Intervention services and Child Protection and Welfare services.

Abstract

This paper reports on a study into the experiences of professionals engaged in an Irish interagency collaborative project to improve the response to families where parents had a diagnosed mental illness. The service initiative, known as Crosslinx, ran for six years (between 2003 and 2010) and involved staff from mental health services, child protection services and primary care psychology. Twenty-three professionals involved in the service initiative took part in qualitative in-depth interviews.

The findings suggest that the collaborative working arrangements led to (i)reductions in staff anxiety about addressing children's welfare in families where a parent had a diagnosed mental illness; (ii) an increased awareness of the value of a systemic and family-focused approach in this context.

This paper points to a need for Mental Health policy to recommend Family Focused Practice is promoted and adequately resourced.

Key Words

Family focused practice, Irish, collaboration, joint working.

Introduction

The Interagency Service Initiative, known as Crosslinx, was spearheaded by two consultant psychiatrists, one from Child and Adolescent Mental Health services and one from Adult Mental Health services. The psychiatrists facilitated staff to work jointly across services to deliver a suite of interventions to families where a parent had a diagnosed mental illness including, family psycho-education; advice on enhancing family resilience; parent support programs; psycho-education groups for 12 - 14 year olds, and 14 - 16 year olds; and Family Therapy. In addition, an individual psychotherapist undertook 'attachment work' with parent/s and baby in their home - as part of treatment for post-natal depression.

Over time a complex case discussion group for professionals was developed in response to families where child protection concerns co-existed with parental mental illness. Raising Awareness training about the impact of parental mental illness, and how to access services was developed for staff working with children and adults.

Family Focused Practice

In a mental health service context - Foster et al (2016) defines Family Focused Practice as a concept that refers to how professionals "respond to other family members when an adult or child has the identified mental health problem" (p.2). In 2012 Foster et al highlighted that the term Family Focussed Practice is often used interchangeably with 'family oriented', 'family sensitive' and 'family centred' practices. It is only in the last two decades that the literature both in an Irish and international context has attempted to define the principles and activities underpinning Family Focused Practice. These include considering holistic responses to families that are preventative, recovery oriented, strengths-based and culturally sensitive (McGavin, 2013; Trowse et al, 2013; Grant, 2014; Mental Health Reform, 2015; Ward et al, 2017; HSE, 2018 *Family Recovery Guidance Document*; Grant et al, 2018).

In 2007 Mental Health Reform - a coalition of non-governmental organisations and professional bodies - was established in the Republic of Ireland to sustain consensus and provide a watching brief that the commitments made in the new Mental Health Policy - *A Vision for Change* (DoHC, 2006) were carried out. In their review of *A Vision for Change* in 2015 – 'Nine Years On' – they welcomed the fact that the Irish Health Service Executive had demonstrated their commitment to service user and family member involvement in service delivery – by employing people with 'lived experience' at senior and staff grade levels throughout mental health services. They highlighted that while families valued the roll out of psycho-education for them – they still experienced barriers to involvement in their loved one's care plan, and the absence of any legislation to support this (Mental Health Reform, 2015).

The recent Recovery Framework document developed for Mental Health Services (HSE, 2017) and *A Family, Carer and Supporter Guide* (HSE, 2018) appear to focus primarily on the adult members of families – when recommending that staff be proactive about supporting families. The literature already highlights how the segregation of adult services from children services often leads to adult services not seeing children as part of their remit (Gopfert et al, 2004; Munro, 2011). Grant and Reupert's 2016 study with Irish nurses highlighted an absence of any organizational or policy requirement to engage in whole family approaches when working with parents who had a mental illness.

In the Irish context reports by services for children are more likely to identify the need for cross agency working to address the needs of parents and children. As far back as 2011 a Practice Handbook on Child Protection and Welfare (HSE, 2011) highlighted the role professionals working with adults had in providing information that would assist 'in ascertaining and managing present and future risk to children' (p.29). In 2014 The Department of Children and Youth Affairs (DCYA) produced a policy framework for children and young people in the Republic of Ireland, *'Better Outcomes Brighter Futures'*, which sets out the need for interagency initiatives to improve outcomes for children. Subsequently the DCYA funded the establishment of Children and Youth Services Committees (CYSC) at national and local levels. These include representation for a range of government departments and voluntary organisations. It recognised the 'importance of parental mental health in supporting children's early social and emotional development' (p.54). The first reference to children by a document developed for adult mental health services is in a supplementary guidance document *'Family Recovery Guidance Document 2018 -2020'* (HSE, 2018). It recommends that 'the support needs of young people or children within the family' be considered as part of a 'Needs Assessment for Family members' (p.14). Furthermore in 2018 the national mental health division agreed to fund a national research project which is evaluating interventions to families where parents are suffering from a mental illness. With this funding the Centre for Mental Health Research at Maynooth University established the PRIMERA research project (**P**romoting **R**esearch and **I**nnovation in **M**ental h**E**alth se**R**vices for f**A**milies) (CMHCR, 2018). Currently there are 14 sites nationally involved in the project. The majority of the sites are evaluating Family Talk. Family Talk is a six-week family-based intervention programme – which supports families to gain a better understanding of the parent's mental illness, facilitates family members in talking about their worries and fears, and how best to harness the family's strengths and build resilience. Family Talk is an evidenced based intervention developed by William Beardslee in the United States in 2007 (Beardslee et al., 2011). Mental Health services in Galway Roscommon and Mayo in the west of Ireland are one of the research sites. An interagency service initiative, known as *Crosslinx West*, led by adult mental health services, and supported by the TUSLA's local Children and Youth services Committee, are facilitating staff involvement in the evaluation of Family Talk. To date sixteen staff – ten of whom are social workers – have trained to deliver Family Talk and are actively encouraging families to take part in the research project. It is expected that the research findings will be published in 2021.

Collaboration and Joint Working

The benefits of collaboration arise from a recognition and appreciation that the needs of public service clients are multifaceted and require a more sophisticated and integrated response (Savage et al., 2010). The literature in relation to the impact of parental mental illness on children highlights the complex interplay of environmental and genetic factors that can predispose, trigger and sustain patterns of psychopathology and hence impact on parenting capacity (Beardslee et al., 2011; Herbert et al., 2014; Cooper and Reupert, 2017). Authors agree that effective multidisciplinary working requires agencies to identify areas of mutual interest and accept a level of interdependence (SCIE, 2012; Chong et al 2013). Other studies highlight the role organisational philosophy and culture can play in acting as barriers to achieving collaborative objectives (Morrison, 2002; Wong and Cummings, 2009).

Method

Drawing on an interpretative/constructivist methodology, a qualitative case study approach (Yin, 1994) was adopted to collect data in relation to the nature of the interagency initiative – particularly its activity levels (i.e. referrals rates and its structural functioning); its historical background; as well as professionals' views and experience of the service initiative. The overall research question was: 'is an integrated service response a more effective way to address the impact of parental mental illness on children and families?' (Killion, 2013).

In this article the author is reporting on the in-depth interviews with twenty-three professionals – twelve of whom had direct involvement with the project and eleven others who referred in to the project or had a lead role in developing it. The in-depth semi-structured interviews were conducted with the aid of an interview guide - consisting of open-ended questions that prompted discussion on professionals' understanding of the aims and objectives of the project; their experience of, and use of the service provided by the project; their views on outcomes of the project; whether they considered the project a success or not; their recommendations for an ideal version of the project; and how they conceptualised mental illness. Participation was voluntary and all participants provided written informed consent. Ethical approval for this study was obtained from the Health Service Executive and Trinity College Dublin.

Thematic analysis was used to identify themes from the interview transcripts (Boyatzis, 1998). Using Hudson et al., 1999 theoretical framework for collaboration, emergent barriers and enablers for joint working were organized and grouped. In order to establish comprehensiveness in data analysis, the interview transcripts were read multiple times to identify key issues. The transcripts of the interviews were coded using Nvivo (Smyth, 2006) data management package and analysed thematically.

Limitations of the Study

Service user involvement, choice and control are now considered critical for successful implementation of policy (Cameron and Lart, 2003) and the absence of their views in this study is a significant limitation. Over a period of months access to service users was negotiated with lead clinicians through a detailed process of seeking ethical approval. Ethical approval was granted. However, in the absence of a lead practitioner, at the time planned to conduct the focus group, access to service users was blocked, and unfortunately the opportunity to access service user's views was lost.

Limitations to the study include its focus on one specific service initiative, and its small data set, limiting the possibility to generalise findings. An additional limitation arose in regard to participant selection, and the limited representation of one key group of professionals - such as psychologists.

Finally, interviews were conducted eighteen months to two years after 'the first phase' of the service initiative. This time delay may have affected respondents recall in relation to their experience and contact with the service, both for respondents who remained on in services and those who had left. The critical factor in recall is that of salience – the extent to which the phenomenon remains prominent in the minds of the participants. Two respondents had already retired from employment in local services, and one was due to take retirement. However, for those who had retired or were about to retire their reports of their experiences were likely less constrained by 'organisational politics' and may have been the richer given this freedom.

Findings

The two main themes that emerged from the data analysis were the role joint working played in enabling practitioners to reconcile their professional values with the aims and objectives of the project – and the role trust played in facilitating this process.

Outcomes reported on by study participants included a greater insight into other services; an increased insight in to the subjective experience of mental illness; an increased comfort in working with children and addressing child welfare concerns; and an adaptation of a more holistic approach to service user's needs.

The process of supporting (particularly non-social work) staff in being more comfortable around addressing child welfare concerns was triggered by one of the lead psychiatrist's efforts to garnering staffs' trust to work together to manage and resolve these tensions. The quote below from a lead psychiatrist captures this process:

"I think in the first few years we found it really difficult to engage the parents and I think it was only when we did some work within the team, the adult team initially say…through the social worker, to get people on board, I think then they were more reassured. Even just referring them to the social worker on the team, even though it was the mental health social worker, would raise alarm bells, but I think over time she managed to get buy in from people and they did take part then" - (Psychiatrist AMHS).

Discussion

It appears that the use of a joint working approach was beneficial in resolving issues of professional values and roles. Cameron et al., (SCIE, 2012) argued that 'successful joint working requires that practitioners need to reconcile their professional values with the aims and objectives of the initiative' (p.17). However, the findings in this study indicate that 'successful' joint working *enabled* practitioners to reconcile their professional values with the aims and objectives of the project. As well as providing role support, the findings suggest that joint working also provided an increase in worker's sense of role adequacy and legitimacy. In addition, the commitment of some respondents to the philosophy of the initiative, along with the maturity of professionals involved in the joint work (both in terms of their experience and their expertise) facilitated certain tensions being resolved, and the continuance of the project.

The findings highlighted the key role the two psychiatrists, as middle managers, played in garnering the trust of professionals involved in the project to engage in joint working and joint learning. Given the absence of any dedicated resource this service initiative was based on an informal model known as a 'network model' (Hudson et al., 1999). According to Hudson et al., 'reputation, friendship, interdependence and altruism are key features of relationships within this model' (p.255). They also highlighted three conditions which enhanced the development of trust: an investment in personal relationships; an appropriate calculation of risk; and adherence to principled conduct. Wong and Cummings (2009) reported on the influence of authentic leadership behaviour on trust and work outcomes of health care staff. Evidence from other studies (Mayberry and Reupert, 2009; Bailey and Liyanage, 2012; SCIE, 2012) highlight the instrumental role middle managers play in gaining wider organisational support for putting policy in to practice. The autonomy the two psychiatrists accorded to team members to develop various aspects of the service initiative with minimal support or scrutiny is another indicator of the levels of trust operating within the service initiative.

Conclusion

The literature highlights that policies and strategic service planning alone will only have a limited impact in embedding family focussed approaches in to practices – and that a challenge to organisational culture is also needed (Grant et al, 2018; Tchemegovski et al, 2018). Arguments about client confidentiality and data protection sometimes used for not engaging with other family members (MHR, 2017) - need to be challenged. The questioning of the evidence base for family focused practice is another argument put forward to not dedicating time and resources to this work. The outcome of the PRIMERA's evaluation of family-based interventions within Irish mental health services should go some way to addressing that argument. The scoping exercise completed by the Centre for Mental Health Research (CMHR, 2018) in preparation for this study identified that some mental health professionals are already engaged in family focussed practice. In addition, 'authentic leadership' (Wong and Cummings, 2010) from middle and senior managers will be required to ensure policies are implemented and a 'Think Family Approach' becomes embedded in practice in service for children and adults. Another option would be to support family focussed practice through legislation. Norway, Finland and Sweden introduced legislation in 2010 to 'promote mental health and disorder prevention for dependent children in health services for adults' (Solantaus et al., 2010, p. 891). 'Family Talk' developed by Beardslee (2011) has been adapted in Norway and Finland to assist with implementing statutory requirements. Finally, it would be useful to gather data on the interagency structures that need to be in place to support this work across services. This data could be used to inform future service development and policy – and ensure resources are dedicated to the most effective services or collaborative initiatives.

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Declaration of Interest

The author reports no declaration of interest. The author alone is responsible for the writing and content of the article.

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BOOK REVIEW: IRISH TRANSATLANTICS 1980-2015: NEW CONNECTIONS ACROSS AN OLD CIRCUIT

Author: Íde B. O' Carroll

Cork University Press, 2018
ISBN: 9781782052524I

Irish Transatlantics brings to life the stories of some of the 'New Irish' migrants to the United States. It explores how, from the 1980s to present times, Irish people's journey to the United States changed from emigration; a one-way story, to that of transatlantic migration; where the two nations became able to trade in human capital and opportunity.

The book is a collection of narrative interviews with Irish people from the worlds of construction, the arts, law, social work, education and business. Each person's narrative explores their own motivation for leaving Ireland. The stories have a common thread of young people searching for more opportunity, economic or social, than Ireland had to offer them at the time. The reader learns of the universal difficulty people had in adjusting to life in American cities and, in most cases, how the same people learned to love their adopted homeland. The stories then diverge down different paths. Many of the interviewees put down firm roots in the United States and prospered in their chosen fields. They speak of the relentless ambition and drive that characterises working life in America and how this drove them to succeed. Others saw their time in America as an experience that provided them with opportunity and education at a time when Ireland had little to nothing to offer young people. With their experience of life 'across the pond' they were able to return to Ireland with enhanced prospects and fortune.

We read how a number of crucial factors differentiated the 'New Irish' from the previous groups that emigrated from Ireland to the USA during the economic recessions of the 1950s and 1930s. The key difference of the typical migrant arriving into JFK was the level of educational attainment. Universal free secondary education was introduced in Ireland in 1964 and third level education became increasingly attainable to the masses. This resulted in Irish immigrants being almost universally literate and educated to a good standard.

Coupled with being from an English-speaking nation, Irish migrants were well placed to prosper in their chosen fields, and we see this detailed through the stories of the interviewees.

We learn how technological innovations have changed the experience of Irish Migrants in recent decades. One interviewee describes hand writing letters to his family in Ireland and phoning two or three time a year at most at a cost of $3 per minute. The same man today has multiple WhatsApp groups with family and friends in Ireland and his children get to see their grandmother of Facetime every week. Transatlantic flight becoming more affordable has allowed people to maintain physical contact.

A theme explored with each of the interviewees is the 'draw' back to the homeland. The people who decided to return to Ireland speak of Ireland being a safer place to raise their children and growing tired of the culture of a relentless pursuit of success and money at the expense of personal happiness. Economic prosperity in Ireland offered those contemplating a move home, the prospect of a good standard of living. Thanks to globalisation and Ireland's low Corporation taxes, some returning migrants were able to secure jobs in Ireland with the same firms they were leaving behind in the United States. Those who chose to stay and build their lives in America still speak of a desire for their own children to be aware of their Irish heritage. The struggle between people's professional an economic priorities and ambitions and their desire to be close to their families and the draw to the familiar is a theme that runs the length of the book.

Although the stories are compiled from information gathered as part of in-depth academic research, the editing and flow of the book ensures that the human stories take centre stage. The wide variety of stories and personalities keeps you engaged throughout. The book is very readable and presents the individual stories without any of them feeling laboured.

If a fault had to be found, it is easy to observe that almost all of the individuals presented are quite successful in their respective endeavours and the book does not include those for whom the 'American dream' did not come true. Undoubtedly there are countless 'New Irish' who did not prosper in the United States and whose hardship was compounded by emigration, not alleviated. This group would naturally be much more difficult to identify and research so them not being reflected is understandable.

This book will be of use to people interested in modern Irish history and social change. The main strength of the book is that it allows the stories of the interviewees to reflect the story of modern Ireland. This is a book that, rather than focussing primarily on macroeconomic data and demographics, focusses on people who embody these trends and changes.

Reviewed by John Finn

BOOK REVIEW:
THE MELTDOWN KIDS: SENSORY SOLUTIONS TO EVERYDAY SITUATIONS

Authors: Linda Plowden OT and Hugo Plowden

Therapy Space Books, 2018

The Meltdown Kids is a collection of seven short books explaining the sensory reasons behind some of the behaviour difficulties or meltdowns that children can present with. In a concise manner the authors explain how fear and distress can cause children to act in ways that families find difficult to contain. They aim to help parents and families to support children with sensory and nurturing strategies and they promote the importance of understanding, consistency and patience.

Each book is a self-contained story about a child experiencing a sensory processing disorder, how this impact on how the feel and how the people around them react. For example, in the first book we are presented with the story of Jody a schoolgirl with a sensory processing disorder and attachment difficulties. The story recounts the challenge she has in getting ready for school each morning. As the story progresses, we hear how Jody struggles with putting on her clothes, how the feeling of the labels and fresh clothes cause her to feel upset and become so overwhelming it makes her want to get back into bed. We see how the family become increasingly exasperated and how this leads to the feelings of anger and upset rising even further. Through the the help of an OT Jody's parent gain insight into how Jody is feeling, and the family try new strategies to overcome them.

Each book is linked to a day and deals with a different problem or sensory processing disorder. Tricky Tuesday is the story of a boy with Autism who becomes upset and angry when his routine in school is changed. Wobbly Wednesday is the story of Ben a boy with Developmental Coordination Disorder (DCD) or Dyspraxia who struggles to manage PE in school, he plays in goals in school and lets in too many goals causing the boys in his class to be upset with him. In Terrible Thursday Katie finds a supermarket overwhelming and this book give a clear description why the lights, noises and colours in supermarkets can have this effect. On Frightening Friday, Jack a boy with Autism get angry and upset when he is in a new restaurant, the book gives a clear outline of the importance or preparing children in advance of going to new places. On Scary Saturday we find out how Nathan how has ADHD struggles to enjoy a Birthday party while trying to control his impulsive behaviour, he gets in trouble in the swimming pool and at the party, this experiences of constantly being in trouble is one that many children with ADHD could relate to. Finally, in Stressful Sunday Ryan a boy with DCD finds his homework very difficult to complete.

The books are presented in a clear and concise manner, with complex themes and diagnosis explained in a way that both parents and children can understand. They cover a range of practical and everyday issues that families deal with, regardless of whether or not a child has a diagnosis or sensory processing disorder. They are beautifully illustrated by Peter McNaney and the stories have a simple structure that manages to show the reality of the challenges children with sensory processing disorders, ADHD or Autism experience. Each book ends with a brief description of the particular sensory processing disorder that was at play in the story.

The books give a very clear and concise explanation of the work Occupational Therapists complete with children with Sensory Processing Disorder. This would be very useful for families, as the role of an OT is often unclear for many people.

Due to the nature of the book and the intended audiences each story reaches a clear and neat conclusion. The adults learn to understand the sensory difficulties and the child practices the strategies recommended by the OT. Each book ends with the resolution of the problem. This creates a hopeful and non-pathologizing narrative and would be helpful for families struggling to view their difficulties in a different way. For some the overly neat resolution of difficulties might not resonate with their experience and could be off putting. I would recommend the book for families struggling with challenging behaviour or if a child is due to visit an OT. It would be particularly helpful for families with primary school children that are attending CAMHS or Disability services.

Reviewed by Eoin Barry

BOOK REVIEW: CHILD TO PARENT VIOLENCE AND ABUSE: FAMILY INTERVENTIONS WITH NON-VIOLENT RESISTANCE

Author: Declan Coogan

Jessica Kingsley Publishers, 2017
ISBN: 9781849057110

Having first encountered the Non-Violent Resistance (NVR) model (Coogan & Lauster, 2015; Omer, 2004; Omer, 2011) while on a Social Work placement in CAMHS in 2015, I was delighted to have the opportunity to review this book. In my current practice, working primarily with families in a community setting, I re-encountered the issue of child to parent violence and/or control and began to further research the available texts in this area, only to find that the initial practitioner handbook (Coogan et al, 2015), had been supplemented by this text. This book is based on the challenges known as child to parent violence and abuse (CPVA), a relatively recently identified form of violence within the family in Ireland (Coogan, 2016). CPVA occurs when a child under the age of 18 years uses tactics of abuse and/ or violence to coerce, control or dominate parents or those occupying a parental role, such as grandparents or foster carers (Coogan, 2016; Coogan, 2018).

The book is the based on the author's PhD study in which he devised an action-based research intervention model for practitioners encountering CPVA within their practice. The study emerged as a result of practice-based dilemmas and what the author describes as the relative silence in social work and policy literature about CPVA (Coogan, 2016). The author argues that narratives and practice regarding familial violence are often limited to the dynamics and prevention of adult-initiated violence. Thresholds, based on harm to children, are the focus of intervention for statutory support, however, what can be offered when it emerges that a child is the source of controlling or violent behaviours? Central to the book is the NVR model which is described as a 'brief, systemic and evidence supported model for intervention specifically with child to parent violence and abuse' (Coogan, 2018:72). The author aims to increase the reader's knowledge and skills in relation to understanding and responding in a systemic way with parents/carers being the primary focus for the intervention. Central to the NVR model is psychoeducation and the therapeutic support of parents in responding to this concern. The book is divided into two sections both of which provide a wealth of practice-based knowledge and academic theory woven in an accessible format.

Part one of the book focuses on the theoretical framework underpinning responses to CPVA, as well as the research informing the NVR approach. This section consists of six chapters and begins by providing the reader with a comprehensive introduction to CPVA and many of the debates within its periphery. Critical analysis is undertaken in pertinent areas such as debates regarding Domestic and Gender Based Violence, children being framed as perpetrators or victims within CPVA, as well as intergenerational cycles and exposure to domestic violence. Parental styles are discussed with analysis regarding their relevance to the child-parent relationship.

The author also provides an in-depth review of international practice-based-responses to CPVA, followed by ten Good Practice Principles that can guide practitioners and agencies in assessing and supporting families where CPVA arises, as well as a framework for conversations amongst colleagues in discussing and responding appropriately to this issue.

Building on the foundation of theoretical and critical debates in part one, the subsequent section introduces and provides the reader with the pathway to integrate the NVR model in thinking and practice, with clear guidance as to the framework and its methodological application. The fundamental areas within NVR are outlined such as de-escalation, increased parental presence and engaging support networks. In chapter five, solution focused therapy as an integration tool with NVR is argued, given that both models envisage a short-term approach with an emphasis on strengths, resources and focusing on capacities. The author gives a wide-ranging insight into solution-focused sessional work through in-depth case studies from practice as well as the core aspects of this approach such as drawing attention to difference, the miracle question and working with families already existing strengths. This section then moves to the eights core sections of the NVR model which comprises of:

- Parental engagement and commitment to NVR
- Increased parental presence
- De-escalation skills
- The support network
- Family announcement
- Acts of reconciliation
- Refusing orders and breaking taboos
- The sit in protest

Significant attention is given to the initial assessment and engagement with parents followed by an outline of ways of working with parents in adapting practices and promoting hope. Of particular note was the concept of parental presence and a new authority. The author describes how when parents encounter CPVA, they can often withdraw their presence, and not just by physical proximity. This section promotes the importance of parent’s focusing their attention and recognition to their child’s behaviour and needs, as well as affirming a physical and psychological presence to mediate, provide comfort and reduce tension in family life. A core strength of the book is the use of case studies, practice examples and rich moments for the reader to reflect on the provided material, as well as their own practice. The author’s enthusiasm and expertise within this area is evident. The book overcomes the challenge of publishing a text rich in academic rigour yet, being accessible to a diverse readership. The author is keen to describe the approach within this text as a model, rather than a programme, and there is no mention of fidelity, implementation science or structured manuals for group or family-based work, which is refreshing. The eight core concepts of NVR are clearly outlined with the argument that they can be adapted (to individual circumstances or in succession) based on where each family is situated.

The acknowledgement of practitioner’s existing skills base and NVR as an additional tool within practice is advanced. The author does not claim that NVR is a panacea for complex problems but envisages the model as an additional tool within practitioner's existing skills and knowledge. In an area where supports are primarily focused towards children this text, through a systemic, strengths-based approach, views the parents/carers with commitment and appropriate support, as being the focus for implementing change in their own lives. As noted by Bowlby (1951: 84) 'If a community values its children it must cherish their parents'. The NVR approaches outlined within this text certainly does this, through a coherent and systemic approach rooted in psychoeducation and therapeutic delivery. I am delighted to recommend this book to the IASW readership and believe that it should be an essential book present in the offices of those in the helping professions, as well as being a core text within social work/allied healthcare programmes.

Reviewed by Seán Lynch, Social Worker and PhD Candidate.

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BOOK REVIEW: BLUE BOTTLE MYSTERY: AN ASPERGER ADVENTURE

Author: Kathy Hoopmann

Jessica Kingsley Publishers, 2001
ISBN: 1853029785

This short book is a heart-warming story about a boy called Ben who has Asperger Syndrome. The book is easy to read (takes about an hour) and is suitable for children and parents alike. It would also be suitable for teachers or indeed anyone who works with children. The author of the book is a primary school teacher and children's author who has been involved with children with Asperger Syndrome for many years. The book is written through the eyes of a young boy who often gets into trouble at school with his teacher and gives greater understanding why some children find the world to be a more difficult and sometimes complex place to make sense of. The book cleverly highlights the range of difficulties experienced by Ben on a day to day basis including his unusual interests in gathering rubbish and stones from the school yard, difficulty understanding rules, his repetitive and sometimes obsessive behaviours. As Ben's adventures at school continue the book highlights how children are often seen as different to their peers. They can have difficulty relating to others and difficulty saying what they are thinking or feeling.

When Ben is diagnosed with Asperger's suddenly things begin to change and make sense especially to his teacher and his family. The book ends on a lovely note when Ben with the help of his father and grandmother is able to move to a new house and one year on is able to attend the wedding of his father .... to his teacher! Overall this book is fun to read and explains in simple terms what Asperger Syndrome is. As a Social Worker on an Early Intervention Team I would recommend it to parents and also to siblings. A lovely read!

Reviewed by Julie McBride

BOOK REVIEW: COUNSELLING SKILLS FOR SOCIAL WORKERS

Author: Hilda Loughran

Routledge, 2018
ISBN: 9781138504202

The title of this book is the least inspiring aspect of what is a detailed examination of how social workers can utilise and enhance their professional skills and marry them to theoretical frameworks.

Loughran begins by disseminating what we mean by ‘counselling skills’, the difference between informal and formal counselling and crucially, the distinction between being a ‘counsellor’ and utilising counselling skills in the social work role. This sets a theme for the chapters that follow in the examination of what differentiates conversations in a social work setting from informal communications and how we may utilise theoretical frameworks in those conversations.

The next seven chapters are each devoted to a particular counselling skill, e.g. talking, listening and questioning. The concepts are not new – all social workers know the terms ‘reflective practice’ and ‘active listening’ – but I would challenge the reader not to come away with a substantive and thought-provoking nugget of information that can enhance their practice in each one of the skills outlined.

For example, in the chapter on ‘Listening’, Loughran offers a detailed look at the skills involved in listening in a professional context and the interconnectedness of the skill of listening with the skills of processing, empathising, utilising professional knowledge bases and demonstrating respect for the service user. She goes on to create a profile of ‘a good listener’ and then examines barriers to listening, both conscious and unconscious. She references the particular skill of listening and recording at the same time although this is further discussed in the chapter on assessment.

In the chapter ‘Thinking, Processing and Reflective Practice’ Loughran offers the analogy of learning to drive to illustrate the concept of conscious and unconscious competence, suggesting of course, that experienced drivers operate with unconscious competence. As she states, she is not a fan of unconscious competence and suggests that our thinking skill and being conscious of the skills we are employing is critical to good social work counselling skills.

Each chapter contains useful exercises, some of which can be done alone but many of which are better undertaken in small groups. An example is an exercise on page 160 in the chapter titled ‘Empathy, Reflection, Reflective Responding’. This involves one person saying something like “I’m really upset at work”. Others in the group can ask questions such as “Do you mean that you are annoyed with people at work?” but the person who made the statement can only answer ‘yes’ or ‘no’. The point of the exercise is for the questioners to think about and understand what their own preconceived ideas of the statement might be and how able they are to recognise these preconceptions and gain an understanding of what the speaker is actually trying to say.

This chapter delves into reflective practice in some depth, considering tone and question/ statement responses as well as distinguishing for example, between simple reflections which demonstrate understanding of what has been said and complex reflections which allow for a service user to consider change rather than induce a resistant response. One interesting point is the consideration of whether empathy can be learnt. Recent research suggests that *"… careful attention to clients builds new neural pathways that facilitate empathic ability while also allowing counsellors to become aware of behaviours that limit empathy"* (pg. 157).

Part II of the book considers the application of the previously discussed skills to method, and there are three chapters in this section; Solution Focussed Work, Motivational Interviewing and Group Work. Each chapter contains a brief summary of the theoretical framework of each model and looks at how some of the skills might be employed within that model.

There are ten appendices which are linked numerically to various chapters. Space does not permit a detailed look at each appendix in this review but in general the appendices consist of illustrative case studies and further exercises to build understanding. For example, Appendix 4.1 (linked to the chapter 'Thinking, Processing and Reflective Practice') begins with a statement made by an 18-year-old man who was convicted of assault. The appendix gives a long list of possible responses to the statement and asks the reader to consider what theories and methods might have influenced each particular response. Loughran then makes her own suggestions.

This book is a significant piece of work, rather than a quick read to be dipped into, although each chapter could be digested individually. It would be useful for both student and experienced worker alike although in my opinion it will be most valued by those workers who are comfortable in their practice but looking to challenge themselves to take their expertise up to a new level. For anyone though, it is a valuable read.

Reviewed by Rohana Reading

BOOK REVIEW: POST-QUALIFYING MENTAL HEALTH SOCIAL WORK PRACTICE

Authors: Jim Campbell and Gavin Davidson

SAGE Publications Ltd, 2012
ISBN: 9781848609952

Contents: Introduction: Mental Health Social Work in the UK - Locating Policy, Practice and Post-Qualifying Education; Policy and Agency Contexts; The Legal Context; Models of Mental Health and Illness; Addressing Discrimination; Listening to Service-Users' Needs; Listening to Carers' Needs; Working with Individuals; Working with Families; Working with Communities; Multi-Disciplinary Working; The Role of the Approved Mental Health Professional; Conclusion: Looking to the Future.

Focused on mental health social work in the UK, this book covers a range of areas from models of mental health to policy, agency contexts, working with families and the centrality of service user needs along with legal issues in respect of the role of the Approved Mental Health Professional or AMHP (the nearest comparable role in Ireland in mental health being the Authorised Officer role).

While this book is aimed at qualified social workers possibly looking to move into the area of mental health or indeed those who have been in practice for some time and wish to enhance their reflective practice and critical thinking skills, the book is equally useful to students of social work preparing for placement or considering working in the field of mental health social work. None withstanding the focus on UK legislation, policy and the AMHP role, the book is also useful to social workers internationally. Chapters such as those focusing on working with families, listening to the views and wishes of service users, multi-discipline working and engaging with the concept of discrimination, cross global boundaries in social work and as such this book provides a very clear, accessible and interactive format to consider these topics form a social work perspective.

The book is divided into two distinct sections. The first part of the book which includes the Introduction chapter and chapters 1-3 covers, according to authors Campbell and Davison, "…four 'core knowledge areas". These chapters inform the content of the rest of the book (chapters 4-11) which focuses on applying theory to practice in the context of the preceding chapters. Each chapter follows a similar, user-friendly format. Learning outcomes are identified at the beginning of each chapter, 'exercise boxes' populate various parts of each chapter, encouraging the reader to engage with the material they have just read and to critically reflect on it and a recommended reading list is included at the end of every chapter. This is a very smart format as it allows each chapter to exist in a standalone capacity while at the same time each chapter links very nicely to the one preceding and the one succeeding it. For social workers working in the UK, the chapters also very helpfully include reference to the National occupational standards (NOS) ("…statements of the standards of performance individuals must achieve when carrying out functions in the workplace, together with specifications of the underpinning knowledge and understanding") and advises which NOS for social work is relevant to the chapter being read.

Campbell and Davidson do a good job of engaging critically with a substantial amount of theory, practice issues and debates relevant to mental health social workers. The book has a strong social perspective and human rights focus but equally it does not shy away from outlining and discussing the more ‘control’ functions of mental health work where social workers must balance concepts of social justice, human rights and the centrality of lived experience with legislation, policies and procedures which may be coercive or punitive in nature.

The inclusion of clear ‘theory to practice’ examples throughout the latter chapters are great. I particularly liked the example of Sean and Annie Murphy (pg. 64) in Chapter 4 *Addressing Discrimination*. The clear explanation of how a mental health social worker could (or should) work with this family from a personal (level 1), community (level 2) and political (level 3) level was very welcome and clearly articulated the multiplicity of skills a social worker must employ both within themselves, at an interpersonal level and at a wider societal level in order to do our jobs ‘right’.

Finally, I really appreciate Campbell and Davidson taking the time to write a book like this. Reading each chapter, it struck me as to how complex and highly skilled the work of mental health (and indeed all) social work is. Working in mental health can be emotionally taxing, vicarious trauma is a constant potential and the complexities of multidiscipline working cannot be overstated. Reading this book allowed me some time to take stock of the vast amount of knowledge each mental health social worker brings to their work, from the very first assessment (noting the overview of what a typical mental health social worker will hold in their mind during even a brief initial assessment on pg. 102 was really affirming as a frontline practitioner) to the scope for community work approaches within mental health (see pg. 127).

This book is a strong addition to any mental health social workers library, and I encourage others to take time to read it and to use it for team reflective sessions, individual supervision sessions or continuous professional development events

Reviewed by Kerry Cuskelly

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OBITUARY

Margaret Beaumont

It was with great sadness that IASW learned of the death of Margaret Beaumont who died on 11th April 2019 after a long illness bourne with dignity and acceptance. We are very grateful to the Beaumont family who provided us with this beautiful tribute to Margaret.

Tribute to Margaret Beaumont from Cait, Margaret's youngest daughter

Hello, my name is Cait and I am the youngest of Margaret's four daughters. On behalf of my father Piaras and my three sisters, Cliona, Mide and Helen, and Margaret's three sisters, Ann, Barbara and Siobhan, we would like to thank mum's friends, of whom there are many, her former work colleagues and her neighbours, for their concern and support for Mum.

Cliona, Mide, Helen and myself would also like to thank our partners, friends and work colleagues who have supported us over what has been a very difficult twelve months.

One of the things that have kept all of us going during this time has been the incredibly positive response that everyone who has come into contact with Mum has had about her as she faced her final illness with dignity, acceptance and fortitude. Elegant, funny, gracious, compassionate, intuitive and kind are just some of the words used by others to describe mum and that has meant an awful lot to us, as this was very much the wife and mother that we knew and loved.

Margaret was born on 3 February 1935 in Cookstown, Co. Tyrone, one of seven children, her sisters and her brothers, Michael, Desmond and Jimmy. She attended boarding school at Loreto College, Rathfarnham, and here she cultivated life-long friendships with a number of classmates who continue to meet monthly for lunch. Mum moved to Dublin permanently when she married Piaras in 1959 and in 1962 they set up a home in Strand Road. Mum loved living by the sea and was enthralled with the seasonal arrival of the Brent Geese, the full moons over Dublin Bay, the drama of winter storms and the lazy summer afternoons.

One of the distinguishing features of Margaret's life was her ability to reinvent herself and take on new challenging roles. Having worked as a full-time housewife when we were little, she made the decision at the age of 41 to attend university and graduated from Trinity College with a degree in Economics and Social Sciences. She then worked for over twenty years as a social worker with the Eastern Health Board in Park House, specialising in fostering and adoption. Instead of retiring at the age of 65 Mum decided to embark on a whole new career. Having completed an MSc she became a child and adolescent psychoanalytic psychotherapist. Mum absolutely loved this work and was wholeheartedly committed to improving the lives of children and their parents or guardians who for many complex reasons required additional support with their relationships. She continued to practice until she became ill last April and my sisters and I were always so proud of being able to boast that our mother was still working at the age of 83.

Over the course of her three careers Mum made new friendships as well as maintaining old ones and always enjoyed meeting up with all her friends and spending time with them over the years. Mum loved lots of things. She was an avid reader and was always recommending books she had read so that she could share the stories she had enjoyed with as many people as possible. She loved to travel and was delighted to accompany Piaras on the Royal Irish Institute of Architects tours to cities such as New York, Chicago, Moscow and Paris. In later years she frequently came to visit myself and Mide in London and Kent, and for her 80th birthday, the four of us took her to Vienna to celebrate over a memorable weekend.

Closer to home our family spent regular summer holidays in the West of Ireland in Carraroe and later Piaras and Margaret visited Cashel, Clifton and Renvyle where the scenery and serenity of Connemara drew them back year after year. Mum loved to dance, and she always grabbed the opportunity to do so at the Institute of Architect's annual conferences dinner dances. She was partial to a glass of Sauvignon Blanc, never Chardonnay, and watching University Challenge on the telly, although I think that may have had more to do with her fondness for the presenter, Jeremy Paxman, than the challenging questions asked. In a very private and quiet way Mum was a devout Catholic and her faith did give her strength in these last, hard months. She was an enthusiastic candle lighter and my sisters and I benefited from this over the years. More recently Donal, Aoibhe, Rosa, Martha and Liam have availed of this service with their Maimo instructing them not worry about a thing as she would be lighting candles for them, and so everything would turn out all right.

Mum was a wonderful companion to Piaras and they shared so much over their many years together. They supported each other in their respective careers, supported their children and grandchildren, shared their love for art, music and Irish culture and most importantly their love for one another. We are so sad that Margaret won't be with us on Thursday to celebrate their 60th wedding anniversary. For us four daughters, mum meant everything to us. She taught us that failing was ok but giving up was never an option. She always stood up for us and we always knew we could rely on her. She taught us to have empathy and compassion for others and to be kind. She encouraged us to be ambitious and that is was never too late to try something new. I spend a lot of my time researching ordinary women who led extraordinary lives. Reflecting on this over the last few days I have come to realise that my own Mum was one of these women, ordinary and yet extraordinary, all at the same time.

Tribute to Margaret Beaumont from Mary Cullen

Our dear friend and esteemed colleague, Margaret Beaumont died on the 11th April 2019. She had been ill for just over a year, an illness borne and accepted with her characteristic graciousness and great dignity. In this, as in so many other aspects of her life and work she proved to be a great model and inspiration to those of us who knew and worked with her in whatever capacity that entailed.

Margaret qualified as a Social Worker having completed her studies in the University of Dublin, TCD, in 1980 as a mature student. She relished the learning and practice aspects of her training. During this time, she completed a placement in Donnybrook Social Services where her colleagues in the Eastern Health Board Community Care Area 2 first got to know her. She later worked in the Social Work Department in Killarney Street, Dublin for a number of years. Margaret truly enjoyed working here and established enduring good professional and personal relationships. She was greatly appreciated for her sense of humour and story-telling capacities which enhanced the positive team spirit in Killarney Street.

Margaret moved to the Fostering Resource Group in the 1990's. This was a specialist fostering service which served the social work community care teams in the former Easter Health Board Region. She developed notable skills in her work with foster-carers, her direct work with children in care and her on-going support to social work teams. She was a much loved and valued team member in this service. She was an 'expert' in attachment theory, with her work having an enduring influence on social work and social care practice in the Eastern Health Board, now Tusla, The Child and Family Agency.

Margaret had an avid interest in training and in updating her skills during her career. She had been introduced to direct work with children through the original British Agency for Adoption and Fostering's training. This was facilitated by Nessie Bayley's experiential course for social workers the 'In Touch with Children Training'. Margaret would go on to lead this training herself in a wide variety of settings. She trained in the Marte Meo therapeutic methodology of supportive communication and went on to become a trainer with the HSE Marte Meo Project. Later she returned to TCD and completed a M.Sc. in Child and Adolescent Psychoanalytic Psychotherapy from 1995 to 1997. Foster carers and young people in care benefited from her work over many years until her retirement.

Post retirement Margaret worked in the Dublin North East Social Work Service in Dunshaughlin as a Child Care Consultant until the onset of her illness. She served on their Foster Care Committee and her wisdom, commitment and work was greatly valued within the service. She had a deep respect for carers and staff alike and an unwavering commitment to the children with whom she worked. In tandem with her TUSLA work, Margaret had a private practice, and taught on a variety of child care courses including in her old alma mater, Trinity college. All of us who knew her in a professional and personal capacity were truly blessed to have had access to such a good empathetic, caring and supportive listener. She loved her work and made an enduring and vital contribution to her profession right up to the end.

Margaret had a wonderful family, whom she loved very much. To her husband of 60 years, Piaras, her daughters, Clíona, Míde, Helen and Caitríona, their partners, and her beloved five grandchildren, we offer our deepest condolences on their loss. Margaret was a wonderful role-model to all of us in her working life and personal friendships and is greatly missed.

On behalf of IASW I wish to extend our sincere condolences to Margaret's daughter and our colleague Cliona Beaumont (IASW member and Senior Medical Social Worker at Mater Hospital). To her husband Piaras, daughters Mide, Helen and Catriona; grandchildren Donal, Aoibhe, Rosa, Martha and Liam, sons in law Gerald, Patrick and Ray; sisters Ann, Barbara and Siobhan; relatives and many friends.

OBITUARY

Noreen Kearney

It was with great sadness that IASW learned of the death of Noreen Kearney who died peacefully on 26th October 2019. Noreen was former Dean of the Faculty of Business, Economics and Social Studies at Trinity College Dublin. She was a founder member and former President of IASW. Since her passing, IASW have been touched by the many tributes that have been paid to Noreen from her friends and colleagues.

Sheila McCrory (Head Medical Social Worker, Crumlin Childrens Hospital) recalled fond memories of her lectures and good sense of humour from her days in college, and how she came to the pub with them when they finished college. *"I liked the way Noreen used to say every agency should take students, and it didn't matter what conditions were, it would get students used to the real world. On one occasion she even famously said "take two, they're small!"*.

Tribute to Noreen Kearney from Caroline McGregor (Formerly Caroline Skehill)

I first met Noreen in my second year at Trinity when I progressed to Year 2 of the BESS to start my social work career. This was 1989 and I was nearly 19 years old. A few years later, Noreen was my PHD supervisor from my second year onwards. My PhD question was about how social work had come to be identified as the lead profession in the expansion and front-line child protection and welfare services. Noreen strongly advocated for community based social work and this shaped the lens through which I explored this. I also came to realise, under Noreen's guidance, that I could not address my question without looking at the history of the profession and the wider context. To help me do this, Noreen opened up her world of contacts and networks within different dimensions of social work and I am very grateful to her many friends and colleagues who patiently addressed my sometimes naïve and ill-informed questions at that time.

I remember that I was very resistant to turning my PHD study towards a more historical focus at first. During my undergraduate years, I have to admit, I had naively failed to appreciate fully the value of Noreen's accounts of different moments in her own past practice or developments within the profession. And I was inpatient to focus on the present and what was coming into the future. And here I am, 30 years later, still passionately advocating in my work for a history of the present approach in our thinking about social work and child protection. I am glad I heeded her advice at the time. It has shaped my critical understanding of social work and has formed the basis of the work I have developed since then.

Noreen and I continued to work together after I left TCD and after she retired. One of our most rewarding –and challenging – collaborations was our co-edited book published in 2005 on the history of social work. This provided a great historical overview of a range of different fields of social work from authors who had practiced at different moments in the past and in different fields. Noreen's knowledge and understanding of the breath of social work was exceptional. We didn't always agree on the same interpretation of certain aspects of history but that was always OK because she always engaged in open, constructive and professional dialogue aimed at improving practice, policy and education.

I last saw Noreen during the summer and felt so proud to have had the opportunity and privilege to have been her student, colleague and friend. I have learnt so much about leadership and commitment to professional social work education and practice from knowing and working with Noreen. I wish I had thanked her more often for all of the inspiration, support, challenge, learning, fun and laughs I have had in her company over the years.

May you Rest in Peace Noreen.

Tribute to Noreen Kearney from Victoria Somers

There are a number of women yes, all women who stand out for their contribution to the establishment of the social work profession in Ireland, and chief amongst them with particular reference to mental health social work was Noreen. She came to work as psychiatric social worker in the then Eastern Health Board in the late mid to late sixties. It was a changing time for psychiatry in Ireland' with the move towards community psychiatry, the development of catchment areas and the opening of St. Loman's hospital as an open community-based hospital. The move towards the community meant for the first time, patients were treated mainly at out-patients clinics the difficult circumstances many of them were exposed to was recognised and addressed. As a single social worker there was little, she could do so she set about influencing and educating not only clinical directors but administrators as to the contribution social workers could make in the psychiatric service.

As a result, she was instrumental in setting up the trainee scheme and I was lucky enough to be one of those trainees. Under this scheme you spend a year after your basic degree as a trainee social worker, you did your professional training on trainee salary and worked for a least two years in the mental health services following. in this way Noreen managed to appoint professional social workers in the adult and child mental health services of the EHB. and succeeded in the most difficult task of obtaining offices for them. She would accept nothing less than suitable accommodation, she set high standards as mark of a quality service which she was a strong promoter of both in social work and the mental health services. Her vision of a mental health service was broader than a purely clinical approach, she painted a wider canvas and viewed community action as part of promoting positive mental health. She was involved in community groups particularly in the Ballyfermot area which had a high rate of poverty and unemployment at that time, thus laying the groundwork for her later chairmanship of Combat Poverty. She was the first social worker to be appointed to the Eastern Health Board and as such promoted the development of social work within the board at community care level.

The late Nora McPartlin and I were privileged to have Noreen as our supervisor in the St. Loman's service in our trainee year. Two raw recruits whose only experience of psychiatric hospital was a visit of observation as undergraduates. She was not a believer in a gradual induction instead we were assigned to our area team not realising until later that she picked the teams with great care, the ones that would give us not only learning opportunities but were welcoming and supportive to trainee social workers. She was what all a good supervisor should be, a teacher patient with our rawness and inexperience Continuing our education in discussion of our caseload keeping always in mind our professional principles. She mentored us and always available to us and guided us through tricky situations we would find ourselves in and tolerant of our many misdemeanours including getting stranded with car trouble, but woe betides if records were not up to date and notes for supervision not prepared. She tried somewhat unsuccessfully to introduce us to process recording as this would be expected on a professional course. She was above all above all a role model. From Noreen one learnt to hold one's own from the not always welcoming fellow professions to be confident of our role and contribution. It was not all work, Noreen introduced us to gin on a Friday and instructed us always to wear lipstick and cautioned us about the perils of parties in the doctor's res in St. Brendans.

Competition for a much sought-after place on a professional course was keen, It was a tribute to the trainee scheme that trainees all went on to complete their professional training.

Noreen became my supervisor once again when she was my tutor for my M.Litt research. without a doubt it would never have been completed without her help, though at times it did not feel helpful especially after one or two tense phone calls concerning missing deadlines.

Noreen was a strong supporter of the IASW. As trainees we were expected to attend meetings join the association and later when qualified to contribute. She viewed the IASW not only as a representative body for social workers but also as a positive force in promoting change within society to make it more equal and to promote high quality public services. . . she was a feminist in the days before we knew what that was, never afraid to take a stand and fight her corner if necessary. I remember her telling of the interview board back then when the only female candidate was asked about her child-care arrangements, incensed Noreen than asked the same of the remaining male candidates, that was Noreen righting a wrong, taking a stand.

Thank you, Noreen, for all you have given the profession, for me personally as a role model.

Tribute to Noreen Kearney from Vivian Geiran (Director Irish Probation Service)

I was very sorry, as I am sure were many of our colleagues, to hear the sad news of Noreen Kearney's recent death. I have only fond memories of Noreen, at a personal as well as professional, level. Apart from her warm and engaging personality, and her many qualities, Noreen had a deep and enduring connection with the Probation Service and the wider criminal justice system, and particularly for the important place of social work in that system. This is something that Noreen demonstrated in various ways. Perhaps most significantly from our perspective, Noreen was a member of the Expert Group, established by Minister for Justice, Equality and Law Reform, John O'Donoghue TD, to review the structure, organisation and work of the Probation Service, and which submitted two reports to the Minister, in 1998 and 1999. Those reports published two decades ago, helped to bring the Probation Service into the modern era, as part of an interconnected justice system, and laid the foundations for what became the modern Irish probation organisation we have today.

Noreen Kearney made no small contribution to that review process and what flowed from it. For that, among all her other achievements, we are especially grateful and appreciative.

Tribute to Noreen Kearney from Bernard Hall

I was more than a little saddened to learn of the death of Noreen Kearney who I remember vividly as a Lecturer in the Social Studies Department at TCD when, working for CCETSW, I visited in the 1980s.

CCETSW, the no longer extant social work course approval and monitoring body based in London, was responsible for the United Kingdom but, strange as it seems in retrospect, Ireland as well, so also at that time to the two other universities in Ireland then offering social work courses, UCD and UCC. When I was appointed as a social work education adviser at CCETSW my planned role fluctuated depending on the interviews at each stage of selection I reached, social care, mental health, and then on appointment, none of these but instead 'Ireland and The World'. There followed several memorable years with visits to Dublin and Cork, also meeting up with Irish Association of Social Workers representatives at Conferences such as the International Association of Social Workers at Stockholm.

On all the occasions when I met her Noreen would ferret out the purpose of the meeting, contribute much wisdom and beyond that, a profound care for social work, workers and their clients. Also, in my memory bank are hospitable qualities of warmth, humour and kindness whether over a meal or during a theatre trip. Like several people I met at that time I lost contact with Noreen after my Irish social work visits ceased when CCETSW was no longer involved.

Was it Hegel, or ascribed by someone to Hegel, who said, 'whose life lives on in memory, he is not dead, he is only distant'? For 'he' read 'she'. Noreen will be long remembered. May she find peace at rest.

On behalf of IASW I extend our sincere condolences to Noreen's sister Peggy, brother Eugene, sister in law Joan, nephews, nieces and her wide circle of friends.

The IASW Journal Guidelines

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: administrator@iasw.ie and journaleditor@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.

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.

All-Ireland Social Work Research Conference Consortium

Award Winners

The All Ireland Social Work Research Conference Organising Committee
Eavan Brady, Dr. Niamh Flanagan, Kerry Cuskelly & Sarah Donnelly

Aine McGuirk, IASW Chair, John Brennan, IASW Vice Chair *(back row)*
Senator Colette Kellher, Sarah Donnelly, AISWRC Organising Committee and Majella Hickey, Chair of the IASW Journal Committee *(front row)*

Room Management Volunteers

footsteps

rest, relaxation, recuperation, recovery

Footsteps, (the operating name of the Convalescent Home Stillorgan) is a long established charity providing one off grants to patients in need of convalescent care, following surgical or medical treatment in hospital. The grants are available countrywide and will usually cover the cost of one week's nursing home care or equivalent cost to cover other convalescent support while recovering from a hospital stay. The aim of the grant is to provide assistance to the patient to enable them to return to independent living.

All applications are considered on a case by case basis and ***MUST***, in the first instance, come from social workers, GPs or other healthcare professionals. Application forms are available on request. For further information or to make an application please contact **footsteps** via email **footstepsinfo@eircom.net**

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Help to create an Ireland where every young person's mental health is valued and supported.

In 2020, Jigsaw are opening two new services in Tipperary and Wicklow - date TBC. Jigsaw will be recruiting Social Workers to work as part of a multi-disciplinary team in these new services.

Jigsaw will be seeking to recruit Social Workers for the following roles:

- Jigsaw Clinician
- Senior Jigsaw Clinician
- Clinical Manager

If you are interested in these future roles, please register your interest by emailing Niamh.gilleece@jigsaw.ie

About Jigsaw:

At Jigsaw we are committed to leading a nationwide transformation in the area of youth mental health. By joining our team, you will play a key part in helping us to create an Ireland where every young person's mental health is valued and supported. We have a strong presence in communities across the country, with our 12 Jigsaw services currently providing mental health support to young people experiencing mild to moderate mental health difficulties. As an organisation, we're continuing to grow. So if you have the skills and experience we require, along with the passion to support young people on their journey, we want to hear from you.

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