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SOCIAL CARE WORKERS IN IRELAND

-Drawing on Diverse Representations and Experiences

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MPhil Social Care, PG Dip Art Therapy

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**Thesis submitted in fulfilment of the
requirement for the**

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Education,**

National University of Ireland, Cork.

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Declaration

I declare that this thesis is my own work, except where otherwise stated, and has not, in total or part, been submitted to any other institute.

Signed

Date

Abstract

This thesis presents a multiple case study of the experiences of twenty-six social care workers. It addresses the core research question of ‘how is social care work experienced by workers in diverse settings in Ireland?’ The study’s first contribution is its diverse, yet in-depth analysis of Irish social care workers’ practices, identities and contexts. In other words, it examines ‘what social care workers do’ in different services. Previous Irish social care studies were located in just one setting, and were focused on service users (Graham, 2011; Byrne, 2014; Brown, 2017) or students (Finnerty, 2012) rather than social care workers’ experiences.

The study outlines the diverse, disjointed representations, or ideologies of social care that emerged from an openly patriarchal, predominantly Roman Catholic society, characterised by religious voluntarism, deserving/undeserving poor distinctions, and an ad hoc, administrative merging of diverse helping professions. Given Irish social care’s disjointed development, I applied an integrated lens to understand how participants represent their diverse professional practices, identities and contexts. This lens engages the key domains of situated learning, holistic social pedagogy, and sociopolitical influences on social care. Focused interviews and arts based photo elicitation generated rich metaphors of practice which demonstrated workers’ professional learning, roles, and shared rituals of providing care and creating diverse, homely spaces. The data was analysed through Yin’s (2009) six stage approach to multiple case studies, and a form of visual analysis, coined as *visual reading*, complements traditional textual analysis.

The second contribution of the study is thus the identification and re-presentation of situated knowledges developed in learning to ‘do’ social care work,

defined as either ‘indigenous’ or ‘shared enterprises’ (Wenger, 1998) which both inform, challenge and exceed those captured in forthcoming registration, regulation and proficiency frameworks. The study’s key findings are presented in three data and analysis chapters under the themes of workers’ practice, identity and context. Beginning with the workers’ personal journey into care, the findings suggest that workers are motivated from their formative years to claim and then perform the roles of helper, advocate, whistleblower, team-member and key-worker in their professional life. Worker identity is first developed in education, especially when exposed to lecturers from the discipline of social care practice, and when supervised by a social care worker on placement. In relation to social care contexts, workers demonstrated that irrespective of the building or service, all were aware of the use of distinct spaces for purposeful social care work, and the most common included the kitchen, the car, the office and getting outside into the community. Also, all research participants discussed the importance of making their setting feel homely and welcoming.

Experience of direct practice with others, i.e., the social care relationship, was defined as *the* fundamental collective experience or *shared enterprise* necessary to claim the identity of social care worker. This relationship is ideally holistic and experienced through embodied practice involving the head, the heart and the hands/body. However, it is undervalued and under threat due to austerity-based, market-driven and new managerialist institutional change. These findings can contribute to informing and contesting the Social Care Registration Board’s understanding of social care work in diverse settings, given forthcoming statutory registration.

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Glossary of Terms

CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CORU	Health and Social Care Professionals Council
CURAM	Biannual magazine for members of Social Care Ireland
HIQA	Health Information and Quality Authority
HETAC	Higher Education Training Awards Council
H&SCP	Health and Social Care Professionals
H&SCPA	Health and Social Care Professionals Act (2005)
IASCE	Irish Association of Social Care Educators
IASCM	Irish Association of Social Care Managers
IASCW	Irish Association of Social Care Workers
IASW	Irish Association of Social Workers
IP	Individual Plans
ITB	Institute of Technology Blanchardstown
JCSCP	Joint Committee on Social Care Professionals
NCEA	National Council for Educational Awards
NQAI	National Qualifications Authority of Ireland
OMCYA	Office of the Minister for Children and Youth Affairs
PCP	Person Centred Plan
PLC	Post Leaving Certificate Programme
QQI	Quality and Qualifications Ireland
QuAdS	Quality in Alcohol and Drug Services
SCI	Social Care Ireland
SCW	Social Care Worker
SU	Service User
SSI	Social Services Inspectorate
TCI	Therapeutic Crisis Intervention
TUSLA	Child and Family Agency
UCC	University College Cork

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Chapter One What is Social Care? Ireland at a Crossroads

1.1 Introduction

For Social Care practice,

“Having an openness to learning is a prerequisite, as the learning associated with this work is so expansive and never-ending. The good enough worker never really reaches the point where they can say that they have arrived” (Ormond, 2014, p. 262).

Ormond (2014) conceptualises social care practice as an openness to learn by a worker who is constantly questioning the internal and external influences and limits on practice and self. This thesis employs an integrated conceptual framework of situated learning, social pedagogy theory and sociopolitical theory to understand the experience of social care practice in diverse settings in Ireland. This framework views situated *learning* (Ormond, 2014) as the central role of the *social care relationship*¹, which is under threat from the multiplicity of neoliberal requirements that have become embodied within practice (Mulkeen, 2009).

Considering Wenger’s (1998) observations, learning occurs within the relationship situated in each setting, in the overlap between identity and social systems. “Learning as participation is certainly caught in the middle” (Wenger, 1998, p. 13), where workers negotiate for relational practice in a liminal space shaped by the forces of new managerialism (Conroy, 2004; Garfat and Fulcher, 2012; Lynch, 2012). This study is concerned with understanding practice through the worker’s story; their “histories of learning” (Wenger, 1998, p. 87), situated in different spaces.

¹ This term was adopted within this thesis to define the specific relationship between the social care worker and other(s) in their care. The characteristics of the social care relationship is defined within Chapter Six.

1.1.1 Research Question and Objectives

The core research question is ‘*How is social care work experienced by workers within diverse settings in Ireland?*’ Given the diversity and disjointed development of Irish social care discussed later, an abbreviated way of viewing the main research question is ‘what do social care workers in Ireland do?’ ‘What social care workers do’ is based on the service in which they work, the specific tasks, duties and policies which frame their day to day practice and how they are identified and professionally valued within the multi-disciplinary team and management structure of the organisation. Due to the diverse nature of social care with different service user groups in both day and residential contexts, the practice of care is defined and structured by the setting, which includes how the social care worker is identified and valued.

The central research question is examined with respect to these three overlapping domains; the social care *worker’s experience of practice*, his or her *identity* and the specific *context* of practice space(s);

1) Beginning with the experience of ***practice***, the following themes are examined;

- What is social care practice like for workers in different settings?
- How do workers learn about and define practice in a particular setting? How is learning situated and shaped by the specific practice space (Lave and Wenger, 1991)?
- What is the significance of the concepts regimes of competence (Wenger, 1998), liminal situations (Turner, 1969) and the social pedagogical trinity of head hands and heart (aka the child and youth care lens) to understanding social care practice and informing imminent regulation processes in Ireland?

The second domain explores social care workers’ [SCW] personal journey into his/her current practice setting, including what motivated them to become a SCW.

2) In relation to worker ***identity***, the following themes were explored;

- In what ways do SCW's identities develop within social care education and practice?
- What kind of identities are claimed and/or performed in practice and how is identity influenced by relationships within the setting?
- What is the impact of a social care worker/non-social care worker title on professional identity?

This thesis is unique in that it is interested in the experiences of workers in different settings, and how the context has influenced their practice and identity formation.

3) The *context of practice space* was examined through the following sub questions;

- What specific spaces do social care workers gain employment in, and how have these services evolved from residual ideologies of the deserving and undeserving poor?
- What individual differences are experienced within the similar settings or between different contexts? Are there unifying themes and/or domains of knowledge, for social care work within these diverse settings?
- Do social care workers use specific spaces within the service for practice?

The way each social care worker feels, acts and represents their practice is based on their personal and cultural experiences, as well as their knowledge and beliefs based on the sociopolitical ideologies and theories that have influenced them and their practice. Understanding 'social care', embedded within the diverse representations of practice, is central to every question posed and is where this research journey begins.

1.2 What is Social Care in Ireland? Some Developments and Problems

"What are you? To define is to limit. Give me a clue" by Oscar Wilde; *The Picture of Dorian Gray* (2016, p. 218).

Social care is a term used to define a milieu of care based work with ‘vulnerable’ or ‘marginalised’ people in society². In most cases, social care workers are the professionals that work *on the floor*³ sharing daily life events with people, either in residential or day services (Fewster, 2013). The legacy of state subsidiary provision of services, Catholic voluntarism and normative familialism (O'Mahony and Delanty, 1998) and the influence of changing power relations on welfare provision (Foucault, 1977/1995) echo through current social care practice. Social care is historically linked to institutionalised care for children in industrial and reformatory schools (O'Doherty, 2003) and Church-run services for children or adults with a disability (Finnerty, 2013; Franklin and Sanderson, 2014). The profession has broadened to include new domains: child and adolescent mental health, addiction; services for people who are homeless, and community/family support, to name a few.

The first published definition of social care in the Republic of Ireland was provided by the Joint Committee on Social Care Professionals [JCSCP] in 2002⁴. This definition accelerated scholarly and professional debates on the practice of social care and the importance of the language, terms and labels used to define what they do and with whom they work (IASCE, 2005; Lyons, 2007; Share and Lalor, 2009; Lalor and

² The terms vulnerable, marginalised, or ‘people in need’ are often used to define people who avail of social care services. I have tried not to use these labels within this thesis unless their use is necessary or unavoidable. The titles are ‘other’ or ‘service user’, and are used interchangeably. The term ‘service user’ is a reflection of new managerialism in social care practice, discussed later in Chapter Two. The term is used here for necessity only.

³ ‘On the floor’ is a colloquial term used to describe the direct work of social care, which is located within a service that is accessed by the service user.

⁴ “The professional provision of care, protection, support, welfare and advocacy for vulnerable or dependant clients, individually or in groups. This is achieved through the planning and evaluation of individualised and group programmes of care, which are based on needs, identified where possible in consultation with the client and delivered through day-to-day shared life experiences. All interventions are based on established best practice and in-depth knowledge of life-span development” (JCSCP, 2002, p.9).

Share, 2013; Graham, 2011; Finnerty, 2013; Byrne-Lancaster, 2013). Publications from the mid-1990s facilitated the introduction of alternative perspectives of social care, not to replace the traditional definitions with entirely ‘new thinking’ (Jones, 2013) but as a move towards a shared discourse on what constitutes social care professionalism, and an ongoing debate on our use of language. Embedded in the project of professionalising social care (Larson, 1977; Share, 2009) is the issue of accountability. Workers are “answerable to” the service user, the disciplinary norms of social care practice, codes of behaviour and, in the near future, state regulatory mechanisms (Biesta, 2004, p.234; Black and Wiliam, 2009; Kline and Preston-Shoot, 2012; CORU, 2017). As this thesis later addresses, the issue of accountability in social care is subject to the problematic reframing of social care service users as consumers, and the prioritising of bureaucratic tasks over relational, interpersonal work (Svensson, 2006; De Lissovoy, 2013).

During the early 2000s, the knowledge base for social care in Ireland was firmly established by the three editions of *Applied Social Studies: An Introduction for Students in Ireland* (Share and McElwee, 2005; Share and Lalor, 2009; Lalor and Share, 2013) and IJASS the *Irish Journal of Applied Social Studies*. According to Share and Lalor (2009), the lack of one succinct definition of social care is a testimony to the ‘flexible nature’ of the work and a lack of commitment by legislators to provide a formalised structure for the profession. In the 2013 edition, students were invited to “create your own” definition, as “social care practice does not always adhere tightly to any definition” (Lalor and Share, 2009, p. 7). However, the ‘Social Care Gateway’⁵

⁵ Online search engine and directory of social care information hosted by the Institute of Technology Sligo.

definition presents social care as a “profession who work in partnership with others”. This definition was adopted by the Health and Social Care Professionals Council (CORU) established in 2005. Its inclusion here is a testament to the role CORU will play in the development of social care in the future.

“Social Care is a profession where people work in partnership with those who experience marginalisation or disadvantage or who have special needs. Social Care [workers]⁶ may work, for example with children and adolescents in residential care; people with learning or physical disabilities; people who are homeless; people with alcohol/drug dependency; families in the community; older people; recent immigrants to Ireland and others” (Health and Social Care Professionals Council, 2011).

Missing from this definition is an acknowledgement of the influence of the setting on the relationship and also the economic, political, structural or managerial structures imposed on SCW practice. Social care is entering a crucial stage which has implications for SCWs’ professional identities, practice contexts and social care education providers. The CORU definition of social care does not reflect the current position of uncertainty, where workers are ‘betwixt and between’ the practice of diverse titles, private agency work, varying levels of status and role, and the promised land of increased professionalism, legitimacy of title and statutory registration (Turner, 1969; Department of Health and Children, 2005).

1.3 Study Context and Rationale: Ireland’s Liminal, Pre-Registration Social Care Phase

In 2010, I was asked to represent IASCE, the Irish Association of Social Care Educators, on the executive of the newly formed representative body Social Care

⁶ Presented as ‘practitioner’ on the website, but ‘Social care worker’ is the only term protected by the Health and Social Care Professionals Act (2005).

Ireland⁷ [SCI] (See section 2.4.4, for more information on SCI). I was nominated by the committee to serve as President from 2012-2014, which enabled me to become more knowledgeable about issues affecting social care workers in Ireland. My access to the visionaries of social care practice, management and education in Ireland has provided an invaluable ‘personal archive’⁸, which I have drawn upon for this study. The SCI annual conference became the hub for debate, and an opportunity to inform the public of the impact of policy decisions on service users and workers. One of the main issues capturing the attention of workers, managers and educators alike, is statutory registration.

In 2009 Ginny Hanrahan, the Chairperson of CORU, presented a paper entitled ‘*Lead the Way, Follow, or Stand Aside*’. Her presentation challenged social care educators to identify the core competencies of social care practice, measurable to a threshold standard⁹, and see if the ‘hat fits.’ At the 2016 Social Care Ireland Conference, Ms Hanrahan again questioned the delegates; ‘Do you know what social care workers do?’ This rhetorical question punctuated Hanrahan’s statement on the complexity of social care and the challenges faced by the Social Care Registration Board in setting the threshold standards of practice. This question highlighted the gaps of knowledge within social care regarding where graduates are located and what they

⁷ In 2010, motivated by the promise of imminent registration, the three representational bodies (IASCW, IASCE, and IASCM) began a process towards unification, and the umbrella body of Social Care Ireland was formed. Social Care Ireland was officially launched in June 2011 by Minister Frances Fitzgerald and became a limited company with charitable status in 2016. SCI, is recognised by CORU as a stakeholder in the consultation process involved in registration. SCI is a non-union, representative body, administered by volunteers from the profession.

⁸ One example of a personal archive is an unpublished interview with Pat Brennan and his past pupils from the Kilkenny Programme presented in Section 2.5.2.

⁹ Threshold standard is the minimum standard a graduate must reach in the established ‘proficiencies’ of social care work. The criteria for the ‘standards of proficiency’ was established by the Social Care Registration Board in consultation with stakeholders and published in May 2017.

‘do’ in these different settings. It is important to note; sometimes it is difficult for me to step out of the normative CORU position when discussing social care, because their regulatory language reflects the official desires of the scholarly discipline and professional domain, to protect the public and increase standards in practice and education. However, as I argue in this study, what social care workers do is always complex, difficult to define in advance, and must be viewed in the inter-relatedness and the internal/external influences on the worker, their practice and specific context of care.

The 31st of May 2017 was a landmark date when CORU launched the ‘Standards of Proficiency for Social Care Workers’ and the ‘Criteria for Education and Training Programmes’, and started the clock ticking towards statutory registration. Representing the Social Care Registration Board, Hutchinson¹⁰ (2017, p. 1-2) stated that “social care is still contested” and going forward the registration board will be investigating “what it means to be engaged¹¹ in social care practice”. The following excerpt from the launch captures the complexity of their task.

“Social care work is a still contested concept in Ireland – there are many elements of what it is, how it happens, where it happens, who should be delivering it, that are still contested. Certainly, the feedback from the consultations we’ve carried out would reinforce that point. There are views along a wide continuum and across a variety of perspectives – even within the Boardroom - and none of this had been settled by the profession itself by the time we arrived at the point of being externally regulated by the State. Not that people hadn’t made a stab at it – (likely many of the faces in this room today in fact) – but simply, either through accident of evolution and history, or maybe because social care is more a collective of practices on a continuum than a ‘Profession’ in the traditional Functionalist ‘theory of the professions’ sense - who knows, as I say ... it’s contested. But the upshot is that, where most of the

¹⁰ Dunia Hutchinson Chairperson of the Social Care Registration Board of CORU.

¹¹ There are many qualified social care workers who are working with various practice titles and within diverse and emerging settings. In order to overcome this challenge CORU and the Social Care Registration Board aim to develop a framework of eligibility to include those who are engaged in social care work, but are identified under a different title.

other professions under the remit of CORU had already established some sort of voluntary regulation, some minimum standards for practice, some clearly defined areas of expertise or even just a widely accepted code of conduct – Social Care faces into this first foray with statutory regulation without those established parameters in place. That means the regulator is establishing those parameters. And that, of course, leads to challenges” (Hutchinson, 2017, p. 1).

As part of the Statutory Registration process, educational providers will have to prove they conform to the standards set by the Social Care Registration Board, irrespective of previous Quality and Qualifications of Ireland [QQI] approval. Exercising their power, the Social Care Registration Board have the legislative authority “to approve” or “refuse to approve” any programme “if not so satisfied” (Department of Health and Children, 2005, p. 34). As a social care educator and member of SCI, I have a vested interest in the registration process and the implications of this mechanism for workers and education providers. Research exploring ‘what is social care’ from the experiences of twenty-six workers, viewed through an integrated theoretical lens of situated learning, sociopolitical theory and social pedagogy, is a valuable resource for this process. It is worthy of note that the theoretical and philosophical insights these tools bring might throw up new complexities, and new difficulties and dilemmas for the process of defining and contesting what constitutes social care work in Ireland.

1.3.1 Engaging the Liminal Phase Before Statutory Registration

This study is set at a key juncture in the history of social care in Ireland, the ‘liminal’ stage of its journey towards statutory registration (Thomassen, 2014). The term ‘liminal’ was coined by Arnold van Gennep in his text *Rites of Passage* in 1908, and

further developed as a concept by anthropologist Victor Turner in *Ritual Process* (Turner, 1969; Werler and Wulf, 2006). van Gennep (1908/2004) conceptualised the rituals of life (for example; adolescence, and childbirth) as a series of temporary stages. Each transitional phase consists of three steps ‘preliminary’ (separation and detachment from the past), ‘liminaire’ (liminal, betwixt and between) (Turner, 1969, p. 95) and ‘postliminaire’ (aggregation, reification) (van Gennep, 1908/2004; Kay et al., 2007). Turner (1969, p. 96) also presented liminality as *liminal situations* a “moment in and out of time”, where the social structures or ‘communitas’ (fragmented into what they have been and what they can be) become visible. ‘Liminal situations’, discussed later, captures the transitions of subject, space and time within social care practice and can provide a theoretical lens to guide workers on how to “live through the uncertainties of the in-between” (Thomassen, 2014, p. 1).

Social care workers in this liminal, pre-registration stage are vulnerable to a neoliberal, new managerial agenda that appears to undermine the Health and Social Care Professionals Act’s (2005) central aim to protect the public. Workers are ‘betwixt and between’ the current experience of diverse titles with varying levels of status and role, and the offering of a panacea where the title ‘social care worker’ is protected, and ‘social care work’ acknowledged and respected by the other helping professions and the State (Turner 1969; Department of Health and Children 2005; Thomassen 2014). The concept of liminality frames the key themes of Chapter Three (Practice, identity and context), where workers are caught between time consuming official regulatory tasks brought about by new managerialism and their pull towards doing relational work with the service users. Figure 1.1 on the following page is an illustration of the

tensions experienced by workers in the liminal phase, portrayed through the metaphor of a 'rope bridge'.



Figure 1.1 Crossing the Threshold to Statutory Registration (Source: Pencil drawing by Denise Lyons)

Social care workers are in this liminal phase, looking towards the unknown space of statutory registration. The rope bridge is a metaphor for the feelings of fear and tension when we move from one state to another, without fully understanding the implications

of registration on practice and education. This introductory chapter continues with my journey, indicating the reflexive lens through which the story of social care work is told.

1.4 Personal Rationale, Journey and Reflexive, Philosophical Lens

Reflexivity is an awareness of the lenses through which we view the world, and researchers need to be both aware of, and able to declare with honesty, how this lens will affect the research (Etherington, 2004; Shaw, 2010). The development of knowledge about social care, presented in this thesis, is based on my research philosophy, or the way I think about the world (Guba and Lincoln, 2005). It includes an epistemological view, or what I believe to be a reliable source of knowledge and an ontological view; my belief of what constitutes reality. Epistemologically, my enquiry into the nature of the “lived-in world” (Lave and Wenger, 1991, p. 35) of social care practice is both constructivist and sociocultural, because I regard the workers as creating knowledge and learning, through their engagement with others within the practice setting. As a lived experience, social care is about learning through relationships, and the magic that can happen within a social care relationship based on trust, safety and genuine care. It also about people, who they are, and how their life journey has influenced them in how they present themselves today. Reflexivity is also an awareness that my life journey and my rationale for becoming a social care worker, are relevant to my relationships, including my relationship with you, the reader.

In school, I was a distracted student, often receiving report cards citing ‘could do better’. Being labelled as academically weak, my focus gradually leaned towards

art, and when I left school, I went to art college. Despite my school report, (see Figure 1.2), I got a job as an art teacher on a Community Education Scheme, that was based in a day service for people with physical disabilities.

A photograph of a school report from 'Y COLLEGE, COOLOCK'. The report is on a light blue background with a white punch hole at the top center. The text 'Y COLLEGE, COOLOCK' and 'SCHOOL REPORT' is printed at the top. Below this, 'CLASS: 5th YR Dec '86' is handwritten in blue ink. A horizontal line separates the class information from the 'COMMENT' section. The word 'COMMENT' is printed in the center of the section. Below it, the handwritten comment 'Will need to keep to the point more. Inclined to waffle a.' is written in blue ink. The report is slightly wrinkled and has a small tear at the top.

Figure 1.2 ‘Will need to keep to the point more. Inclined to waffle’.

After the 12-month employment scheme there, I went back to education as a full-time student. I had a desire to ‘help’ people, and due to inexperience, I thought the disability sector was the only practice setting for social care workers. However, during my social care education, I completed a three-month placement within a children’s residential home for ten teenage girls. I was terrified and felt ill-equipped for the task, but after a few weeks of hanging out¹² (Garfat and Fulcher, 2012) and developing relationships with the girls, I was hooked. This experience indicated the diversity of social care work to me, the depth and continuous nature of the learning involved and how meaningful and important the role was. After college, I continued to work in children’s residential care, first with the girls, and then a group home for ten teenage boys.

¹² ‘Hanging out’ is a term coined by Thom Garfat to encapsulate the importance of spending time informally with service users for relationship development.

Being a social care worker gave me a great sense of purpose, but it was also challenging and scary, especially as the decisions we made had a direct impact on the lives of others. At that time, my social care colleagues included musicians, plumbers, carpenters, security personnel, all employed as permanent social care workers without a relevant qualification¹³. This provided flexibility for employers but offered no continuity or protection for service users. The field of practice was open, unregulated and lacking a cohesive identity. In 2000 when I started to teach social care work, I became more aware of how the field had expanded into a multitude of practice settings, using various terms and with different levels of status. My students¹⁴ thought critically about social care and were motivated to learn, and they taught me about the contemporary issues affecting the changing world of practice. After 2010, the student numbers in my class doubled, with the primary cohort being young people straight from school. As the years passed, I became more disconnected from practice, and unable to answer the question of ‘what social care workers do?’ The chapter continues with an introduction to the integrated theoretical framework that was used to support this study, and answer that question.

1.5 Overview of Integrated Theoretical Framework

This thesis is interested in understanding social care, through the experiences of practice articulated by twenty-six workers. The three phenomena under review, *‘practice, identity and context’* are interrelated, overlapping and mutually relevant.

¹³ A qualification in Applied Social Studies/Social Care or equivalent.

¹⁴ In my early experience of lecturing, the majority of my students were mature, full time social care workers, on part-time leave from their post to obtain a qualification in social care, they were called ‘in-service’ and ‘field-based’ students.

Social care work has evolved into diverse contexts, where practice is situated and figured, holistic and embodied, where workers learn the symbols, meanings and ways of work within the relationship (Lave and Wenger, 1991; Holland, Lachicotte, Skinner and Cain, 1998; Cameron and Moss, 2011). The first theoretical lens; sociocultural theories of situated learning; and the second social pedagogical lens of head, heart and hands, supports a study of relational and emotional practice and shared meaning making within a situated learning experience. Social pedagogy through the framework of head, heart and hands can provide a structure for the development of social care work that embraces the role of education in collaboration with care, which is also in line with the point 18 of the Standards of Proficiency for social care work (CORU, 2017b).

Sociopolitical theory forms the third part of the integrated lens. It is used to outline dominant, residual and emergent ideologies of social care in Ireland, and, drawing on Michel Foucault's analysis of the subjection of the person (in this case, the social care worker), to understand the effects of multiple, but sometimes subtle, everyday institutional techniques on the worker (Schwan and Shapiro, 2011). These tools explain the influence of neoliberalism and new managerialism on the diverse domains of social care practice in Ireland (Smith, Fulcher and Doran, 2013), and workers' need to "be aware of the concepts of power and authority in relationships with service users" (CORU, 2016, p. 7). Influenced by Schachter's (2015, p.229) theory on the benefits of using a 'conceptual bridge' between relevant theories, this integrated theoretical lens of sociocultural theory, social pedagogy and sociopolitical theory provides a model for the study of meanings about practice, identity, the specific

settings or contexts of care. The discussion begins with sociocultural theory and the situated learning of workers in practice.

1.5.1 Sociocultural Theory: Situated Learning

Sociocultural theory is predicated on the work of Lev Vygotsky (1896 -1934), who stated that all learning is influenced by the social and cultural context in which it occurs (Vygotsky, 1978). The central premise of Vygotsky's work is that learning occurs through social interaction, mediated by physical and symbolic tools which are used to interact with the environment (Vygotsky, 1978). These tools are passed down from one generation to the next and are used for understanding, engaging in, and ultimately changing the 'physical world'. Symbolic tools, including language and cultural metaphors, are used to communicate and create meanings about the shared culture, activity and practice (Vygotsky, 1978; Lantolf and Thorne, 2006). Within all contexts including social care work, interactions happen through the use of 'tools' either psychological (language, practice stories, and relationships) or through reification (Wenger, 1998; Hansman, 2001). The term reification is used by Wenger (1998, p. 58) to encompass how participation is made into tangible objects, which is the "process of giving form to our experiences". In the context of social care this can include practice stories that are used to explain decisions made, universal records that everyone knows how to fill in, and the policies specific to each service.

1.5.1.1 The Situated Learning of Shared and Indigenous Enterprises

Situated learning acknowledges a relationship between knowledge obtained through shared interactions and the space in which the learning takes place (Lave, 1991). This situated learning space was named ‘communities of practice’ by social anthropologist Jean Lave and her student Etienne Wenger, in the text *Situated Learning: Legitimate Peripheral Participation* (Lave and Wenger, 1991; Wenger, 1998). As a learning theory ‘communities of practice’ is based on the following principles; a) all people are social beings, b) through knowledge acquisition, people gain competencies, c) knowing is a product of “active engagement in the world” (Wenger, 1998, p. xvi), and d) the fundamental goal of learning is a meaningful engagement (Wenger, 1998).

This thesis is less interested in applying Lave and Wenger’s theory of the development of the student learner (McSweeney, 2011) and is more concerned with how the graduate progresses from newcomer to old-timer (Lave and Wenger, 1991). Also, this thesis is not about establishing social care settings as communities of practice. The focus here is on the *knowledge* or situated *competencies* gained, the *knowing* or understanding of social care practice and the *meanings* created within their situated experience [original emphasis] (Wenger, 1998, p. 4).

According to Wenger (1998), people are in pursuit of multiple ‘enterprises’ in their personal and professional life, for example making a real connection, obtaining goals, helping others and having meaningful experiences. Initially, people decide on the enterprises to pursue and then they actively seek them, individually or by engaging with others who share this pursuit. For example, workers in social care settings learn by engaging with others in the workplace which “results in practices” that are the “property of a kind of community” (Wenger, 1998, p. 45), their specific service. Lave

and Wenger (1991) and Wenger (1998) called these enterprises ‘regimes of competence’. There are ‘shared enterprises’, for example, the common practices of all social care workers, and ‘indigenous enterprises’ which are part of the situated knowledge unique to each setting. Shared practices may include the similarities of how key-working¹⁵ is used within the different settings. Hutchinson (2017, p. 1), speaking on behalf of the Social Care Registration Board queried if social care is “a collective of practices on a continuum”, however, the existence of shared enterprises between social care workers in different settings, may challenge this view.

Wenger (1998) acknowledged that the social learning theory of ‘communities of practice’ has received criticism for its inability to address issues of power in, and external to, the learning environment. Sociopolitical theory is drawn upon to examine the dominant, residual and emergent ideologies influencing social care as well as the everyday techniques through which social care work and workers are produced (see section 1.5.3). For now, the domain of social pedagogy is discussed, given its intrinsic links to the above discourse about the situated learning within specific practice settings.

1.5.2 Social Pedagogy

Social pedagogy is a relatively new term within Irish and Anglophone literature (Hämäläinen, 2003; Stephens, 2013). However, there is a growing recognition of the significance of social pedagogy as a theoretical basis for social care practice and

¹⁵ Key-work is an approach to care where one or two workers are assigned to a specific service user. The aim of this approach is to encourage a more in-depth and meaningful relationship development between the worker and the service user.

education in Ireland (Hallstedt and Högström, 2009; Högström, Nilsson, Hallstedt and Share, 2013). The term ‘social pedagogy’ was originally coined by German educator Karl Mager in 1844 (Petrie, Boddy, Cameron, Wigfall and Simon, 2006). However, the German philosophers and educators Paul Natorp (1854 -1924) and Herman Nohl (1879 – 1960) are considered the founders of the social pedagogical approach to education and practice (Cameron and Moss, 2011; Stephens, 2013). Social pedagogy was first introduced as an alternative approach to mainstream education in Germany (Smith, 2009). The originators believed that the main aim of social pedagogy was to nourish self-efficacy through a combination of education and compassion (Jackson, 2006; Storø, 2013). Natorp defined social pedagogy as “the social in the educational and the educational in the social” (Stephens, 2013, p. 45). Here, social and educational are presented together, an acknowledgement to the social construction of learning (McInerney, Walker and Liem, 2011) and Natorp’s belief in the complete overlap between socialisation and education. Natorp believed all education should be preparation for social life (Stephens, 2013), with a strong community ideology (Hämäläinen, 2003; Petrie et al., 2006).

Social pedagogy is both a practice and an ideology, which defines the direct care work of social pedagogues with children, individuals, or groups throughout the lifespan (Smith, 2012).

“In practice, social pedagogy means working with people in the context in which they live – their life world in a holistic sense” (Högström et al., 2013, p. 20).

In contemporary social pedagogical practice, the worker may sit and have a chat over a cup of coffee (social) with the person they live and work with, and/or support them to fill in a housing application (educational/pedagogical), and/or help the person to

attend a community group advocating for more social housing in the area (social pedagogical). The nine principles of contemporary social pedagogical practice are defined within Petrie et al. (2006) and presented here as Appendix 7. The principles are centred around three main themes, which I have coined as ‘relational shared life experiences’, ‘reflective team member’, and a ‘combined individual and community care focus’ (Petrie et al., 2006, p. 22). Relational shared life experiences stress the communality of spaces, where people live and work in the same space, and pedagogues do practical tasks with, and for, others (Cameron and Moss, 2011; Stephens, 2013).

The phrase ‘head, heart, hands’ or ‘famous trinity’ which now commonly frames a holistic social pedagogical approach was coined by Swiss teacher and philosopher Johann Heinrich Pestalozzi (1746 -1827) (Hayward, 1904). The essential focus of his approach was the development of a child’s natural abilities as a whole person, regardless of wealth or status (Jackson, 2006). Pestalozzi described the head as “all the psychological and intellectual functions that allow us to understand the world and form rational judgements about things” including “perception, memory, imagination, thought or language” (Brühlmeier, 2010, p. 48). However, Brühlmeier (2010) added that it was harder to interpret what Pestalozzi meant when he referred to the ‘heart.’ Heart was not discussed as an abstract concept, but related to “first and foremost the basic moral feelings of love, faith, trust and gratitude, plus also the activity of our conscience, our sensing of beauty and goodness” and using the knowledge from the heart to practise in a moral way (Brühlmeier, 2010, p. 48).

The final stage of the triptych; ‘hands’, referred to the “physical faculties, manual faculties, faculties of art, faculties of profession, domestic faculties or even

social faculties” (Brühlmeier, 2010, p. 48). Pestalozzi believed that each faculty could develop (Stephens, 2013), but that the heart must develop first (Hayward, 1904), and love was a central theme in the development of the heart (Krusi, 1875). This theory can support a critical discussion of concepts of love and touch which can prove challenging for social care workers (Lausten and Frederiksen, 2016). Pestalozzi’s trinity, in collaboration with Lave and Wenger’s (1991) situated learning provides a framework for the discussion on social care practice, identity and context within this study. In the next section sociopolitical theory is used to explain how practice, identity and context of social care, are underpinned by dominant and residual, internal and external forces.

1.5.3 Sociopolitical Theory

As is evident from the thesis title, this study draws on ‘diverse representations’ to in part explain how ideologies underpin workers’ affective and cognitive experience of practice. This thesis accepts the premise that a homogenous view of social care practice does not exist. As such, the key question is what ideas or actions are impacting upon the workers’ experience of practice, in other words, what are the main ideologies and everyday techniques and arrangements underpinning their experience of practice, identity and context. McLellan (1986, p. 1) argues that ideology is “the most elusive concept in the whole of social science”, but in general is the ideas and values in every system which has an unequal distribution of power and resources, and “which system is this not the case?” (McLellan, 1986, p.83). Ideology is a worldview or the ideas and beliefs (van Dijk, 1998) that influence political, social and economic policies. Marx

(1867/2009) argued that at any one time, there are three ‘cultural forces’ of ideologies in play within society.

1. Dominant ideologies; which are shared by the majority, but are invisible because they have been adopted and legitimised within society (Nescolarde-Selva, Usó-Doménech and Gash, 2017).
2. Residual ideologies; these are in the past but can still influence current thinking.
3. Emergent ideologies; new ideas which develop from resistance to the dominant or residual forces (Marx, 1867/2009; Nescolarde-Selva et al., 2017).

Since the mid-1980s, neoliberalism¹⁶ became the dominant ideology informing welfare provision in Ireland, and has become normalised into a “common-sense way many of us interpret, live in, and understand the world” (Honohan, 1992; Harvey, 2005, p. 3). New managerialism, the administrative structure of neoliberalism, operates through three mechanisms of power; “a business-like approach, more internal accountability, and performance management” (Doherty, Horne and Wootton 2014, p. 21; Foucault, 1977/1995). The ideology of new managerialism is evident in social care practice in Ireland, implemented through budget cuts, privatisation, consumerism, and the preference of scientific/ rational accountability over relational engagement. Evidence of this ideology and its effects is presented throughout this thesis. I argue in Chapter Two that as well as reshaping social care practice, neoliberalism has commodified social care education. It has deprofessionalised workers through accountability mechanisms based on outcomes and a revised view of citizenship based on consumer choice (Hoyle, 2001; Evans, 2008). The impact of new managerialism on social care is evident in the mechanisms for performance management (Doherty et

¹⁶ Neoliberalism is an ideology and policy model that argues for a free market economy, achieved through increased competition in the market. This policy promotes Public, Private Partnerships in the belief that commercial and private services are more flexible, transparent, easily regulated and more economically efficient than state services (Harvey, 2005; Lea, 2017).

al., 2014) and the regulatory structures that have become the embodied and legitimate standards of social care practice and education (Harvey, 2005).

Residual ideologies, most particularly those involving Catholic Church-State relations and medical model of care, have influenced the development of diverse social care settings and continue to influence the day-to-day provision of care. While acknowledging the diversity of how social care is defined internationally, I also argue that a culture of charitable voluntarism (Brennan and McCashin, 2001), remnant attitudes to the undeserving poor; and the adoption of Victorian patriarchal ideas on women's role in society, have shaped both the diversity of social care work and its perception as women's work (O'Mahony and Delanty, 1998).

This thesis is interested in how workers' experience these (dominant, residual and emergent) ideologies within their setting. Foucault's theory on the 'disciplinary power' is used to explain how workers, "through specific modes of subjection" are controlled in subtle and often unconscious ways (Foucault, 1977/1995, p. 24). Power is not an external force that controls from the outside in, but a disciplinary power that works through "the apparatuses and institutions" which are adopted and normalised within the subjected self (Foucault, 1977/1995, p. 26). It is "a micro-physics of power, whose field of validity is situated in a sense between these great functionings", within both the social institutions and the social body (Foucault, 1977/1995, p. 26). This argument on the ordering of the self draws primarily from Michel Foucault's (1926 – 1984) text '*Surveiller et punir*', translated as *Discipline and Punish* (1977/1995), in which he traced the changing practices of punishment through time, beginning in the era of 'sovereign power' in the 1800s and the punishment of the body by public spectacle. Foucault's text highlights how power still prevails in modern society, only

now the punishment is directed towards the mind (the soul), through the surreptitious mechanism of surveillance (McHoul and Grace, 1993). This method of social control he called disciplinary power (Macey, 2004).

Disciplinary power includes “the gentle efficiency of total surveillance; of ordering space” and ordering the subject, which includes the methods and techniques which maximise the usefulness of people by controlling the body and soul (Foucault, 1977/1995, p. 249; Macey, 2004). Identity is formed and then subjugated through a person’s interaction with the states ‘apparatus’ or all the techniques of power including “institutional, physical, administrative mechanisms and knowledge structures” (O’Farrell, 2005, p. 129). These social institutions act as mechanisms of training, which produce docile bodies that are first rendered submissive and obedient and then trained to be functional and productive (Schwan and Shapiro, 2011). This training, ‘makes people’, through the use of simple instruments that become integrated within the social body, the soul and the mind; “hierarchical observation, normalising judgement and their combination in a procedure that is specific to it, the examination” (Foucault, 1977/1995, p. 170).

In this age of surveillance, people are made through observation, ‘the gaze’, and believing you are constantly watched from ‘within’, makes subjects that self-regulate (Foucault, 1977/1995). Foucault (1977/1994) began by describing ‘hierarchical observation’ through the example of the army, where the leader’s tent is deliberately placed opposite the soldiers’ tents with the door facing towards them. Surveillance becomes embedded and nested in the space they all occupy, and the soldiers’ self regulate because they believe in the possibility they are being watched. Foucault also wanted to draw attention to how social institutions use time to control

people by recording activities and behaviours. Using this time-tabled system, new crimes and punishments were introduced, people were ranked, measured and defined by a process of ‘normalised judgements’ (Foucault, 1977/1995). Links are made throughout this thesis providing examples of discipline within social care practice; on how space is organised, how the time of the worker and service user is time-tabled and controlled, and how certain practices are regulated and controlled over others. The final instrument of disciplinary power, the examination, enabled experts to exert their power; people were compared, judgements made and the “examination, surrounded by all its documentary techniques, makes each individual a *case*” [original emphasis] (Foucault, 1997/1995, p. 191). The introduction of the examination enables a “whole series of codes” within each discipline to emerge, for example, “the medical code of symptoms” (Foucault, 1977/1995, p. 189-190). The codes, categories, classifications and registers became the techniques of formalising the subject within power relations. Hospitals became “laboratories for scriptuary and documentary methods” (Foucault, 1977/1995, p. 190), a practice later adopted by the administrative and managerial structures of social care services. There are two examples of regulatory structures that are central to the surveillance of social care workers in practice discussed within this thesis, beginning with the regulation of workers through Statutory registration and the regulation and surveillance of practice by the Health Information and Quality Authority HIQA.

Resistance to disciplinary power is difficult because the more invisible the mechanisms of power become, “the little resistance it arouses” (Foucault, 1977/1995, p. 218). The mechanisms of power are invisible because social institutions have adopted the language and discourse of freedom, within the mechanisms of control.

This is an important point because historically it has been the social care workers who demanded ‘increased choices’ for their service users, and now neoliberal ideologies colonise these notions of ‘increased choice’ or ‘more flexibility’. These ideas and arrangements are presented as ‘freedoms’, but in reality are invisible mechanisms which ultimately limit choice and flexibility. The dominant, residual and emerging ideologies of Irish society, are relevant to understanding social care from the perspective of the worker, to comprehend how social care contexts developed and are currently managed, and to understand what influences workers’ experience of practice. Through sociopolitical theory on the dominant, residual and emergent ideologies, and a Foucauldian perspective on disciplinary power, understanding social care work begins by questioning the worker, recognising her/ his story of subjection and the surveillance of self, by self and others, behind his/her discourses on practice and context (Edwards, 2017). Before the chapter concludes with an overview of the thesis structure, I have included a brief introduction to *visual reading*, a new creative methodology for the analysis of textual and visual data.

1.6 Visual Reading-A Creative Methodology

Whenever it was possible and applicable, I have used drawings in my work. When I was a social care worker, I often sat drawing in the shared space of practice, as a way of being with the young person. Sometimes I was asked to draw a portrait, and as I drew in silence, they chatted to me about what was meaningful in their life, hidden within the day-to-day ‘stuff’. Drawing in this space created a shared experience, it felt natural, and was a relaxing and unstructured chance to chat, without purpose or agenda, but it was meaningful work. I also used drawings in my academic work

(Lyons, 2009, 2010 and 2013), to bring life to the text and focus the reader/student on the main themes, through the actions of reading and seeing. I have used drawings in this thesis as self-study - to help me understand and see the big picture, as emphasis – to visualise a point I feel needs further explanation and for analysis through a process I called visual reading. Visual reading is based on analysis of the textual data that is presented in a form other than text. In this case, the visual readings are pencil drawings based on my analysis of the textual and visual data within the study. Visual reading is a creative methodology that encompasses three stages: ‘creative interpretation’, ‘visualising the new’ and ‘expressing the inside out’. In brief, visual reading is relevant to a variety of creative mediums where the researcher *expresses the inside-out* and makes visible their analysis in a non-textual medium, and creates the *new*, their *creative interpretation* of the data through a process of reading and seeing. Visual readings can provide increased clarity for the researcher and enhance the reader’s comprehension of the researcher’s analysis process. This chapter continues with an overview of the thesis structure.

1.7 Research Structure –Thesis Overview

This thesis addresses the question of ‘how is social care work experienced by workers in diverse settings in Ireland? through a multiple case study analysis of twenty-six social care workers, drawing on an integrated social pedagogical, sociocultural and sociopolitical lens. Chapter Two is a primarily sociopolitical chapter, detailing the ideological factors relevant to the formation of Irish social care practice and education. This chapter argues that the disjointed diversification of social care services is directly linked to the historical evolution of Catholic voluntarism in Ireland, and societal

attitudes to the deserving and undeserving poor. The classifying of social care services as originating from welfare ideologies of the deserving and undeserving poor was used as a framework to structure the twenty-six services into three case clusters for analysis, specifically social care practice and context (see Chapter Four). Chapter Two also maps how social care practice has been negatively affected by the retrenchment of fiscal and human resources, and the neoliberal privatisation and consumerisation of care. Social care education is also discussed as disconnected from its practice-based origins and from the needs and requirements of individual services, as it moved from education for care to meeting the consumer demands of a growing student population.

Social care in Chapter Three is normatively presented as encompassing three interrelated dimensions; practice, identity and context. Practice – social care work, described as relational is experienced and performed through the ‘social care relationship’. Social care workers are presented as motivated to help others, and their social care identity is formed initially within education and primarily within the practice context. The workers’ journey into care and the stories they tell about their relationships are relevant to their experience of social care. Context: the work of social care is presented as situated, embodied and holistic within various services with particular regimes of competence. Opportunities are sought to use ordinary places within each service, like the car or the kitchen table, as meaningful practice spaces for relationship based work.

Chapter Four outlines the methodology and provides a rationale for using a holistic multiple case study (Stake, 2006, 2010; Yin, 2009; Merriam and Tisdell, 2016), to collect data triangulated through the use of qualitative focused interviews and the arts based method photo elicitation (Harper, 2002; Lapenta, 2011). The chapter

outlines how I used drawing in this thesis as self-study - to help me understand and see the big picture, as emphasis – to visualise a point I feel needs further explanation, and for analysis, through a process, I called *visual reading*. The rich data from the twenty-six participants were thematically analysed within the three case clusters (Braun and Clarke, 2006) with the support of NVivo qualitative software and framed using Yin's (2009) six-stage research design. The analysis is presented and discussed under the three themes of practice, identity and context. Beginning with the workers, Chapter Five focuses on the claimed and performed identity of workers in diverse settings, and the ordering of the self through ideological influences. Using the integrated theoretical lens, Chapter Six explores how practice stories and metaphors can provide an in-depth account of the workers' experiences of engaging with others. Chapter Seven provides a window to the practice spaces and place which are these diverse contexts of care.

1.8 Conclusion

This thesis presents the contexts of social care as experienced by twenty-six workers in eight different settings and the multiple meanings they share on social care practice. Understanding practice, context and identity within an integrated theoretical framework, provides a rich opportunity for investigating the diverse representations of social care work, to explore how workers learn about practice within specific contexts of care, the meanings they make from their relational work with others, and how their professional identity is formed. I acknowledge that addressing social care through the three domains of practice, identity and context is multi-faceted in conceptual and analytic approaches and ambitious in scope. However, the thesis is

driven by my embeddedness in the social care profession, ongoing scholarship and my history with creative practices. As the forthcoming chapters outline, I intend to examine the situated learning within social care settings where individual workers engage with others to ‘do what needs to be done’, meeting the holistic requirements of the others, within the multiple forces of external and internal power that impact upon their practice (Foucault, 1977/1995; Wenger, 1998, p. 6).

Chapter Two Ideological Factors in the Development of Irish Social Care Services, Professionalism and Education

2.1 Introduction

As stated in Chapter One, Hanrahan (2016) challenged social care workers, educators, and managers to define practice, as an essential preparatory step for the regulation of social care in the near future. In addressing the question, this thesis is focused on social care workers in work, who they are, how they define themselves, and what practice issues they experience each day. However, the work of social care does not occur in a vacuum; it is influenced by the historical, political, economic, and cultural ideologies prevailing in a given society. In this chapter, contemporary social care work is presented as the practice of meeting the diverse care needs of people within a neoliberal ‘welfare’ regime that has introduced the market principles of privatisation, consumerism, and the business management model of new managerialism. New managerialism is experienced through increased regulation, normalised bureaucratic and rational accountability practices, reduced professional autonomy and an altered relationship with the service user.

This chapter argues that three defining factors characterise the complex and disjointed development of social care practice, professional identity and education in Ireland. These are

- (1) The diversification of state-funded social care services¹⁷ (related to historic religious voluntarism, and provision framed around the deserving and undeserving);

¹⁷ One common thread of the diversified social care services is a reliance on government to provide funding. Social care services are administered by either TUSLA (The Child and Family Agency), the Health Service Executive HSE, the Department of Health, the Department of Children and Youth Affairs, or the Department of Justice (Lalor and Share, 2013), depending on the type of service. There

- (2) Despite the onset of professional regulatory standards, the deprofessionalisation of workers (related to the implementation of neoliberal, new managerialist approaches) and;
- (3) The dilution of a collective social care worker identity; through the commodification of social care education by teaching large numbers of students with diverse placement experiences and practice supervision (Lancaster, 2013), and through the use of a variety of job titles for social care work in different sectors, both home and abroad.

By analysing a range of interrelated ideologies, the chapter offers an overview of the historical development of, and current issues in, Irish social care education and practice. It particularly notes the influence of the State and Church on the predominantly female profession of providing care for people with a disability, people with an addiction, a mental health issue, or who experience homelessness, and the services for children in residential care. I begin below by outlining some of the key features of Irish society's dominant neoliberal ideology.

2.2 Neoliberal Ideology in Ireland: Both Dominant and (Re)Emerging

Neoliberalism, although Chomsky (1999) argues is neither liberal nor new, is based on a belief in unregulated free markets, privatised state assets and services, low corporation tax, all designed to undercut democracy and put state services including social care services within the hands of private corporations (Chomsky, 1999; Harvey, 2005; Boas and Gans-Morse, 2009; Bissett, 2015). The financial crisis of the 1970s and 1980s brought into question the welfare state ideology prevalent in the United Kingdom and America (Moran, 2010; Murphy and Dukelow, 2016). In Ireland specifically, this recession warmed public opinion towards a social partnership

are four sectors currently involved in direct provision; informal, the public sector, the private sector and the voluntary (Kiely, 1999; Warren, 2005; Lalor and Share, 2013).

approach to governance, which reduced but by no means ended the institutional and cultural authority of the Catholic Church (Dukelow, 2011; Murphy and Dukelow, 2016).

In 1987, the three social partners; government, employers and unions, introduced *The Programme for National Recovery*, the first of many policies which aimed to reduce wages and taxes to stimulate the economy (Government of Ireland, 1987). The perceived success of Ronald Regan and Margaret Thatcher's 'new right'¹⁸ neoliberal discourse in the 1980s, influenced this developing social partnership towards a neo-corporatist model (Murphy and Dukelow, 2016).

The 2008 financial crisis saw successive Irish governments embrace a retrenchment in spending, that was more severe than the responses to the financial crisis of the 1970s and 1980s (Moran, 2010; Dukelow, 2011). The speed of the property crash, Ireland's immersed position in European Union economics, and the trend of social partners to comply with corporate interests, all contributed to the perfect storm for an uncontested welfare retrenchment (Moran, 2010; Dukelow, 2011; Mac Consaídín, 2014). Irish people became silenced by their own mortgage debt (Coulter and Nagle, 2015) and trade unions were complicit, agreeing again "to pay restraint in return for income tax concessions" (Dukelow, 2011, p. 419), resulting in little resistance to cutbacks in spending. When Ireland agreed to the expensive bailout from the 'Troika'¹⁹, public sector spending within the Republic was under global scrutiny (Mac Consaídín, 2014). The *Memorandum of Understanding between the European*

¹⁸ This 'new right' ideology is a criticism of John Maynard Keynes' Keynesian economics, in favour of a 'monetarism' and free market ideology influenced by Milton Friedman of the Chicago School of Economics (Harvey, 2005).

¹⁹ Troika represent the three monetary institutions; the European Commission, International Monetary Fund and European Central Bank.

Commission and Ireland (Department of Finance, 2010) laid the foundation for the reduction in public sector employee numbers and the privatisation of public services, outlined in the Public Service Reform Plan (Department of Public Expenditure and Reform, 2011).

McGimpsey (2017) argues that neoliberal policymaking was halted during the recession, known internationally as the period of austerity (2008-2016). This post neoliberal phase, coined as 'late neoliberalism' by McGimpsey (2017) is characterised by the move from marketisation to the rules of finance, which becomes a re-justification for the state-market relations introduced through neoliberalism. Welfare policies within this period of late neoliberalism have partly moved on from the mechanisms of new managerialism; marketisation, and privatisation, and are "beyond fiscal constraint to reflect the logic of finance capital" (McGimpsey, 2017, p. 65). Austerity is the state's inability to pay for public services, yet austerity became repackaged as the solution and rescue plan of the state to restore and improve public services, and austerity measures become normalised.

As a result, private companies, voluntary agencies and state bodies compete for resources through a competition that measures input against outcomes. This reconfiguration in the UK has shifted the focus to 'social investment', from outputs to "impact made on longer term 'outcomes'" (McGimpsey, 2017, p. 71). This idea introduces the notion of "return on investment", so adverse experiences of austerity policies are offset against the long-term rewards. These financial mechanisms, under the auspices of austerity measures, have resulted in a "further covering over of the productive, reforming work of late neoliberal regime" (McGimpsey, 2017, p. 79), and

a possible emerging discourse for future social care provision in Ireland. The chapter continues with an introduction to the residual ideologies influencing current practice including attitudes of the deserving and undeserving poor, Catholic voluntarism and patriarchy.

2.3 Diverse Services: A Legacy of State-Church Relations/Ideologies

Roman Catholic orders have played a central role in the development of care provision in Ireland, primarily because of the large number of vocations, and the colonial and early independent state's 'hands-off' approach to the practicalities of caring for others in society (Magray, 1998; Maeyer, Leplae and Schmiedl, 2004; Blasi, Turcotte and Duhaime, 2002). Competition with the Protestant charities also drove the Catholic Church to increase their presence within welfare and educational institutes (Gilligan, 2009). From the 1800s to the 1950s there was a growth in religious orders in Ireland, beginning with the establishment of the Irish Sisters of Charity (1813), Loreto Sisters (1822), Mercy Sisters (1831) and the Sisters of the Holy Faith Order in 1857 (Attwater, 1958; Maeyer, Leplae, and Schmiedl, 2004). Care for the poor began with home visits and the practice of providing food and clothes to the ill and poor from the convent door (Magray, 1998). It is important to note that the State promoted the role of charity and voluntarism in welfare provision, for both moral and economic reasons (Lucey, 2015). Voluntarism, structured through religious organisations, played a major role in the provision of health and care in Irish society (Callanan, 2007). People, mainly women, became involved in the care of the deserving others in society because of a desire to do good (Lorenzen and Lake, 1987b) and as a result of loyalty and devotion

to the doctrine of the Catholic Church (Magray, 1998; Blasi, Turcotte and Duhaime, 2002; Gilligan, 2009).

The first state intervention to deal with the growing numbers of poor in Ireland was in the form of the ‘workhouse system²⁰’, introduced by the British Poor Law Commissioner George Nicholls (legislated by the Poor Law Act of 1838) (Wall, 1958; Magray, 1998). Workhouses provided food and shelter in exchange for labour, but the conditions were intentionally barbaric with family separation, overcrowding, starvation and disease (O'Connor, 1995; Curry, 2011). The Reformatories Act (1858) and the Industrial Schools Act (1868) established large institutions specifically for orphaned, or ‘criminal’ children (Maltby and Maltby, 1979; O'Connor, 1995) and “convents availed themselves of the opportunity to run government-funded institutions whenever possible” (Magray, 1998, p.79). By the 1900s, the Catholic Church was the main organisation involved in services for the poor, people with disabilities, and individuals with mental health issues in Ireland (Pollack and Olson, 2008; Fanning and Hess, 2015).

After 1922, the workhouses were re-appropriated as district hospitals, country homes, or destroyed in the War of Independence (Kiely, 1999; Fanning, 2006; Harvey, 2007). Some of the workhouses were reassigned as foundling hospitals to deal with the growing numbers of orphans and Lunatic Asylums for the placement of the mentally ill (Kiely, 1999; Curry, 2011). The role of the church in the care and education of Irish citizens was ratified within the 1937 Irish Constitution, where the

²⁰ Section 48 of the 1838 Poor Law states, “the workhouse system, which has been successfully applied to depauperise England, may be safely and efficiently applied, as a medium of relief, to diminish the amount of misery in Ireland” (Maltby and Maltby, 1979, p. xxi).

preference was ‘subsidiarity’, through a limited involvement of the state in local family life (Linehan, O’Doherty, Tatlow-Golden, Craig, Kerr, Lynch, McConkey and Staines, 2014). All social care services have a connection to a religious order, either through their origin, funding, or governance. However, in the past ten years, there is a move towards secularised, centrally regulated standards of practice and service delivery. The most visible difference is that lay people, mainly women, have replaced members of religious orders as frontline workers within the contexts of residential child care, services for people with physical and/or intellectual disability, homeless services, addiction, and child and adolescent mental health (National Economic and Social Council, 2005; Dukelow, 2011). The relationship between the Catholic Church and the State continued, and there is evidence of this partnership in the treatment of women in Ireland. This ideology, in conjunction with Victorian patriarchy, redefined women’s place in society and villainised their sexual expression and acts of agency. It is argued here that the legitimisation of a Catholic familial ideology in Irish society, laid the foundations for social care as women’s work and the recipients of this care as ‘objects of charity’ (Clear, 1987).

2.3.1 Women’s Work and the Tradition of Catholic Familialism

Feminist theory (Lynch, 2007; Jones-Devitt and Smith, 2007; Doyle, 2009; O’Toole, 2009) and an understanding of Catholic familialism can shed some light on the legitimisation of gender divisions in Ireland, which ensured women’s role as the primary carers in the home (O’Mahony and Delanty, 1998). In Ireland, the Catholic Church “sought to gain control of socialisation, with its chief tenet, the subordination of women and control over their sexuality through the doctrine of *the home*” [original

emphasis] (O' Mahony and Delanty, 1998, p. 66). The Catholic Church adopted the principles of Victorian patriarchy, where sexual freedom was viewed as immoral, and women were structurally redefined as the bedrock of faith and family (Mahony and Delanty, 1998). Catholic women were encouraged to adopt the imagery of 'Mary', and these 'Marian' followers²¹ or 'Cult of Mary' were vulnerable to the Church's reconstruction of Mary within their doctrines (Hamington, 1995). 'Mary' evolved to an unachievable measurement for 'good', which created a moral polarity. When women failed to reach this goal, or 'Mary's level of goodness', they were viewed as evil, a doctrine which suited the Catholic Church's need to subordinate women (Hamington, 1995). This ideology and its teachers became the "experts of discipline, normality and subjection" (Foucault, 1977/1995, p. 296) and the women who disobeyed, and were not 'good', were viewed by society as 'fallen' (Magray, 1998) and were institutionalised by their families and the State into Church run laundries.

Through Catholic familialism, gender roles remained dichotomised, and women were limited to the 'private sphere' of the home (Welter, 1966; Chambers, 1987; Grant et al., 2004), responsible for all the unpaid domestic duties of care for the family and household (Lavender, 1998). This cult of domesticity²² denied women access to paid work in the marketplace, leaving them oppressed and dependent on their spouse or extended family (Cott, 1977; Fisher and Tronto, 1990). The main employment women could access in the community was the role of carer, although

²¹ The Marian Movement is a term used to describe the activities of groups within the Catholic Church with a particular devotion to Mary. For example, one such group the Legion of Mary, was established in Dublin in 1921 (Hamington, 1995).

²² These were ideas about women as submissive care givers which emerged in England and Ireland between 1785 to 1835 (Cott, 1977) called the 'cult of domesticity' and the 'cult of true womanhood' (Welter, 1966; Chambers, 1987; Lavender, 1998; Lynch-Brennan, 2009).

this position was poorly paid and of low status (Welter, 1966; Cott, 1977; Chambers, 1987; Lavender, 1998; Lynch-Brennan, 2009). It is important to note, there are currently no statistics available on the total number of social care workers in Ireland or their gender. The Social Care Registry when it opens will provide an indication of the number of practising social care workers in Ireland, who are required by position or title to register. The discussion continues with an analysis of the diverse representations and forms of social care that emerged from historical Church-State relations. The first setting included here is residential care for children.

2.3.2 Residential Child Care: The Deserving Poor

As discussed, post-famine²³, poor children were initially placed with their families in the workhouses (O'Connor, 1995; Raftery and O'Sullivan, 1999; McHugh and Meenan, 2013), and after 1868 in Industrial schools for orphans (Department of Health and Children, 2009), Reformatory Schools for convicted children (O'Connor, 1995; Considine and Dukelow, 2009), and Magdalen Laundries for 'fallen women' who were often under the age of 18 (Magray, 1998). These large institutions were structured around discipline and education rather than care, and physical and psychological abuse was a common experience for the many children placed there (Foucault, 1977/1995; Reilly, 2008; Department of Health and Children, 2009). As noted earlier, education was viewed as the structure through which the Catholic Church, through the practices of their wealthier parishioners, could preserve their

²³ Initially, the Poor Law Relief (Ireland) Act of 1838 encouraged every parish to be responsible for their own poor. As a result of this local approach, poor children begged for food, or were put to work (Department of Health and Children, 2009).

mission to win more souls (Fischer, 2016). Children in Industrial schools were redefined as the deserving poor, souls in need of Catholic education and discipline.

The first workers in these large residential units were predominantly Nuns without any specialised training, who at times cared for hundreds of children²⁴ (Clear, 1987; Raftery and O'Sullivan, 1999). The first lay workers in children's residential services were called *child care workers* or *houseparents* and were also untrained and predominantly female (O'Mahony, 2002; Gilligan, 2009; McHugh and Meenan, 2013). In the Reformatory and Industrial Schools System Report (1970), Justice Kennedy, appalled by the conditions of children in care, recommended the closure of the remaining institutions (Department of Education, 1970). Following the Kennedy Report (1970), the Task Force Report on Child Care Services (1980) aimed to review the services for children. The statutory framework for these changes was provided for in the Child Care Act (1991), which was the first child specific legislation since the 1908 Children's Act.

Residential care has changed in the past twenty years primarily influenced by the child care legislation from 1991 to 2015²⁵. By the late 1990s, most children were placed in smaller community-based houses called residential centres or group homes (O'Sullivan, 1999). The average number of children in each community based house is two, and this can vary from a single child, up to a maximum of four children per house (Houses of the Oireachtas, 2016). Also, the overall number of children in

²⁴ Under the administration of the Christian Brothers, St. Joseph's Industrial School in Artane reached peak capacity with 830 boys in 1948, which gradually reduced to 210 by the year it closed in 1969 (OMCYA, 2009, p. 106).

²⁵ Child Care Act 1991, Children Act 2001, Health Act 2004 (42/2004), s. 75, in so far as it amends the Child Care Acts 1991 and 2001; Child Care (Amendment) Act 2007, Child Care (Amendment) Act 2011, Child Care (Amendment) Act 2013 (5/2013), Children and Family Relationships Act 2015, Child Care (Amendment) Act 2015.

residential care has declined²⁶ with most children being placed with foster families or relatives (O'Halloran, 2009; Christie et al., 2015). Some children over 18 years of age will remain in the residential service while attending an education programme, or based on their eligibility to avail of an aftercare plan (Kilkenny, 2012; King, 2014; Child and Family Agency, 2015). This chapter continues with the history of how Irish society has cared for people with a disability and mental health issue.

2.3.3 Disability and Mental Health: Medical and Social Models of Care

After the Poor Law Amendment Act (1834), people with disabilities and mental health issues, although unable to work, entered the workhouse system to receive 'indoor relief' (O'Connor, 1995). The 'Dickensian' completely unsuitable conditions of the workhouse motivated the establishment of the first institution specifically for adults and children with a disability (O'Connor, 1995; Linehan et al., 2014). Influenced by the *Report on Lunatic Asylums Ireland* in 1869, the Protestant 'Stewart Institution for Idiotic and Imbecile Children' was opened that year in Dublin (Finnerty, 2009; Linehan et al., 2014; Kelly, 2016). The organisation aimed to teach people from all religions with a disability, the necessary life and social skills in preparation for returning home (Race, 2007; Kennedy, 2012). However, as people rarely went home, the demand for services increased (Kelly, 2016), and in 1926, the Catholic Daughters of Charity began the process of turning the large workhouses into disability services,

²⁶ In February 2016, there were 337 children in residential care centres in Ireland, representing 5% of the 6,398 children in care (Houses of the Oireachtas, 2016).

converting ten buildings in total across Ireland (Magray, 1998; Harvey, 2007; Kelly, 2016).

The Catholic Church remained as the primary administrator of disability services until the 1950s when non-denominational groups, primarily organised by parents, began to establish services for people with physical and intellectual disabilities throughout Ireland (Harvey, 2007; Kelly, 2016). This marked the beginning of a nationwide movement towards community rather than institutional care (Finnerty, 2013). Services for people with physical and/or intellectual disabilities expanded to include community-based residential homes, respite services (Harvey, 2007) and day services (Paul, 2014).

As disability was linked to illness, a medical ideology or medical model²⁷ became normalised in the care provided for people with both a physical and/or intellectual disability (Cousins, 2007; Edwards, 2017; Edwards and Fernández, 2017). People living at home were collected by ambulance, and the centres were often called ‘clinics’ (Finnerty, 2009, p. 334). Services operating under a predominantly medical model tend to have a multi-disciplinary team²⁸ with a strong nursing component and may employ care assistants²⁹ as opposed to social care workers. Traditionally care assistants provide for the physical and intimate care needs (Dustagheer, Harding and

²⁷ Within the medical model a disability or incapacity is viewed as requiring a medical response or treatment. Described as a sociological construct (McSherry, 2013), the medical model is a view of care from a ‘treatment’ or clinical perspective.

²⁸ Although social care workers are predominantly based within the services, the provision of care for people within specific services for example disability services will also include other professions. Depending on the needs of the service users the team may include nurses, occupational therapists, psychologists, social workers or speech and language therapists.

²⁹ Care assistant is a care role where the worker is required to assist in the physical care needs of people within their own home or disability or elderly care services. The qualification level for care assistant is QQI level 5

McMahon, 2005), and this role is often low paid with a lower prestige to other health and social care professions (Kacen, 2005). Alternatively, services that adopted a social model³⁰ of care, for example, children's residential care, employ social care workers in a more central role within the multi-disciplinary team. In the 1990s, many services for people with a disability were redefined towards a social model of care, and the training of non-medical, untrained personnel as social care workers complemented this approach. As within residential child care, the title 'houseparent' in the intellectual disability sector was replaced with 'social care', to align workers under one pay scale. Although social care work as a title was only formally recognised in the Disability services in the late 1990s, this sector is one of the main employers of social care graduates in Ireland (Finnerty, 2009; Lalor and Share, 2013).

It is also important to state that there is a professional hierarchy within disability services that have a dominant medical approach to care (Finnerty, 2013). There is a value judgement here which placed the medical opinion and their "observation, diagnosis, and characterisation" (Foucault, 1977/1995, p. 246) as superior to the service user's own descriptions, and above the social care workers' professional contribution. In a similar light, the expansion of social care into traditionally medical, non-disability settings has posed a challenge for the profession of social care. This is clearly seen in the field of Child and Adolescent Mental Health [CAMHS] with the introduction of new social care worker posts to the multidisciplinary CAMHS team (Department of Health and Children, 2006). This *Vision for Change* report (2006) includes the role 'child care' worker as one of the

³⁰ The social model emerged as an alternative to the medical model with a focus on societies response to disability or illness.

professions included in the Child and Adolescent Mental Health team, now defined as social care workers by CAMHS. The number of social care workers in child mental health has grown from 16 in 2011 to 41 in 2015 (Health Service Executive, 2014), and these workers are involved in both the treatment and assessment of young people presenting with mental health issues (Health Service Executive, 2012a; HSE, 2015).

‘Care for the elderly’ is another medically based service, although defined as a social care context (Lalor and Share, 2013), the Nursing Homes Ireland (NHI) claim their services employ only care assistants as opposed to social care workers. This claim denies the presence of good social care practice that exists in care settings for older adults (Gallagher and Edmondson, 2015). The discussion continues with another one of the more recent sectors to include social care workers as part of their multi-disciplinary team, homeless services.

2.3.4 Services for Homeless People: The Undeserving Poor

Historically, services for the poor and homeless were provided by the “Daughters of Charity (1922), St. Vincent de Paul (1926), the St. John of God Order (1931) and the Brothers of Charity (1939)” (Linehan et al., 2014, p. 2). Homeless services are directly linked to welfare regimes to alleviate poverty and have emerged from an ideology of homelessness being the result of poor life choices (Bauman, 1998; Lane, 2001; O'Sullivan, 2004; Garthwaite, 2011). Pre-Independence, philanthropic housing trusts and charities tried to alleviate the overcrowding and poor conditions of tenements in Irish cities (Scanlon, Whitehead and Arrigoitia, 2014). For example, the Tenement Company was established in Dublin in 1897 to follow in the footsteps of social worker Octavia Hill in London and help improve the living conditions of families in the City

centre (Kearney and Skehill, 2005). The Housing of the Working Classes (Ireland) Act (1908) marked the beginning of Local Authorities building affordable housing for working class families (Garthwaite, 2011; Scanlon et al., 2014). Irish housing policy³¹ “excluded from its proper consideration many of those who had been termed as outsiders by the influences of Roman Catholic norms” including “people with disabilities” and “homeless people,” (Kenna, 2011, p. 52).

Despite the increase in social housing, homelessness was on the rise, and in 1996 the Dublin Homeless Initiative was created to coordinate a stronger partnership between the voluntary and statutory agencies. Watts (2013, p. 42) states that this was the beginning of Ireland’s “social partnership approach to homelessness”, as opposed to the ‘legal rights’ approach” which was adopted in Europe. Since 2011, the Dublin Region Homeless Executive is the centralised statutory response to homelessness in the Dublin Region (Seymore, 2013), replacing the Homeless Agency. In July 2017, there were 5187 adults and 2973 children homeless in Ireland (Focus Ireland, 2017).

The public response to homelessness in Ireland began to change, and in December 2016, Home Sweet Home³² volunteers took over a NAMA owned property ‘Apollo House’ in Dublin, to house homeless people over the Christmas period (Brophy, 2016; Kelly, 2017). Through their protests, ordinary people challenged the Government to see homelessness, not as a personal problem, but a humanitarian and political crisis (Hansard, 2016). There is also a rise in the number of families becoming the ‘new’ homeless, 1429 families were homeless in July 2017, which is the highest

³¹ The 1988 Housing Act provides the legislative framework for the provision of housing to homeless people, deemed eligible by the local housing authority (Seymore, 2013).

³² Home Sweet Home was established in 2016 as a public response to homelessness. The campaign supported by Brendan Ogle, Glen Hansard and Jim Sheridan, organised volunteers and raised 160,000 Euro for homelessness (Brophy, 2016).

number of homeless families ever recorded in Ireland (Lane, 2001; Garthwaite, 2011; Focus Ireland, 2017). As well as economic issues, pathways into homelessness can include mental health and addiction (Mayock and Carr, 2008; Focus Ireland, 2015). The employment of social care graduates has increased within homeless services, and workers are located within emergency centres, “day centres, street outreach services, food centres, health services, advice services, drug rehabilitation and resettlement services” (Seymore, 2013, p. 415). Addiction services are the final sector employing social care graduates to be discussed within this thesis.

2.3.5 Addiction Services: Further Undeserving Populations

Ireland’s approach to service provision for people with a drug addiction is historically linked to attitudes towards the substance abuse of alcohol. Post-famine, excessive alcohol consumption was common amongst young males, stemming back to the introduction of distilled gin in the 1800s (Stivers, 1976). Father Theobald Matthew introduced abstinence through pioneer groups, for example the Pioneer Total Abstinence Association of the Sacred Heart, which was founded in 1898 (Malcolm, 1986). However, alcohol abuse became more socially acceptable through the role of the ‘pub’ as the social centre (Stivers, 1976; Malcolm, 1986). The Religious Order of Mercy Nuns and in particular Sr. Consilio, established the first treatment centre for alcohol abuse in Ireland in 1966, which was expanded in the 1990s to accommodate drug addiction (McNamara, 2000). Drug treatment in Ireland is categorised under two main types; opiates and non-opiates (Department of Community, Rural and Gaeltacht Affairs, 2009). Opiate use relates to the opium family; heroin, morphine, and codeine, whereas non-opiates include cannabis and cocaine (Bryan, Moran, Farrell, and

O'Brien, 2000). Opiate addiction is generally “concentrated in certain marginalised and poor sectors of society, and in certain geographic areas” (Department of Community, Rural and Gaeltacht Affairs, 2009, p. 10). Non-opiate users are spread across all economic and geographical areas (McNamara, 2000; Doyle, 2009).

The 1980s ‘opiate epidemic’, although mainly located in disadvantaged areas in Dublin, shattered lives and families in Ireland (Doyle, 2009). Initially, treatment was medically based, but an acknowledgement by Government in the mid-1990s led to the development of community-based local Drugs Task Force (Doyle, 2009, p. 385). These agencies performed as a collaboration between statutory and non-statutory service provision and kept the services locally based. The National Drug Strategy 2009 – 2016 aimed to tackle drug use from four trajectories; supply reduction, prevention, treatment, and research (Moran, O'Brien, Dillon, and Farrell, 2001; Department of Community, Rural and Gaeltacht Affairs, 2009). According to the Drug Strategy, treatment is provided in a four-tiered system, beginning with outreach, family and GP services, leading up to residential treatment with a specialised multidisciplinary team (Moran et al., 2001; Leahy, 2011). Many services are aimed to cater for both homelessness, and drug use, including the Merchants Quay Project and the Dublin Simon Community Addiction services, which include detox and residential rehab programmes, low threshold services, day programmes and aftercare, to name a few of the diverse services offered (Bryan et al., 2000; Doyle, 2009).

From the historical discourse of viewing people with an addiction as undeserving, people “with drug addiction were viewed as more responsible for the onset and offset of their health condition compared to the person described as having a physical disorder that requires a wheelchair” (Corrigan, Kuwabara and

O'shaughnessy 2009, 145). Bryan, Moran, Farrell and O'Brien (2000), argue that on the ground, societal attitudes towards people with a drug addiction were mixed, between viewing them as ill or labelling them as a criminal. Attitudinal changes are linked to the level of contact a community has with people with an addiction, and the more personal the experience they have, the more accepting they become (Corrigan and Penn, 1999).

2.3.6 Summary: The Diversity and Ideological Antecedents of Irish Social Care

To summarise, social care services became diversified in no small part due to distinct ideologies emanating from religious voluntarism and notions of deserving and undeserving poor. Those affected by poverty; the homeless, unemployed, and orphaned were treated less favourably than those deemed 'incurable'; individuals with an intellectual or physical disability, or mental health issue (Lane, 2001; Whitebrook, 2002; Finnerty, 2009; Garthwaite, 2011). Disability services emerged within a societal attitude of providing for the 'deserving' and ill within society, or those who cannot provide for themselves (Warren, 2005; Keogh, 2010). Children's services, although emerging from the poverty ideology, were redefined as deserving, when society viewed the child's needs as beyond their control or fault (McAuley and Rose, 2010; Burton, 2015).

The predominantly female social care workforce is employed in diverse settings; including children's residential care; day or residential services for people with an intellectual and/or physical disability; services for people defined as homeless, and services for people experiencing addiction and/or mental health issues. These

settings carry the residue of historical Church-State relations, religious doctrines, less eligibility ideologies, medical and social models of care, that form some of the influences on current practice. However, one of the key contemporary influences on the provision and experience of social care within all services is a neoliberal ideology experienced through the structures of new managerialism; the marketisation of care and privatising of services and the impact of austerity measures on the day to day lived practice of care.

2.4 Neoliberalism, Managerialism, and Deprofessionalisation

Neoliberalism is presented as the dominant ideology influencing social care work in Ireland. As discussed, all public services, including the provision of social care, are susceptible to the changing power relations of government (Foucault, 1977/1995). In the 1980s, there was a shift away from Catholic voluntarism towards a ‘rights based approach’, and a more socially inclusive and egalitarian approach to welfare provision (Larragy, 2014, p. 72). Foucault’s theory of disciplinary power explains how modern society does not rely on external forces or sovereign power to control people because the “norms themselves emanate a power over the individuals as the order is internalised” (Foucault, 1977/1995; Lea, 2017, p. 174). Neoliberalism is effective because it gives the impression that it is not governing or constraining practices, by presenting the illusion of providing more individual freedoms (Lea, 2017).

The structures of new managerialism are “the mechanisms of power that frame the everyday lives of individuals” ... “and places under surveillance their everyday behaviour, their identity, their activity” (Foucault, 1977/1995, p. 77). The impact of

neoliberalism below is discussed in terms of how the discourse was formed, from whom, what anachronistic attitudes or policies are evident and which freedoms are curtailed. With a commitment towards rationalisation, and making the ‘ineffective’ public sector more transparent and efficient, accountability and regulatory structures were developed, including advancing the remit and the powers of regulators (Clarke, 2004a; Clarke 2004b; Lynch, 2012; Lynch, Grummell and Devine 2012). The techniques and methods imposed on social care services, including austerity practices and privatisation, have impacted on the experience of social care provision for both the service user and the worker.

2.4.1 Austerity Measures

In Ireland, the recession was especially difficult for the public sector with “pay cuts and hiring freezes” (Boyle, 2017, p. 224). The workforce moved from a position of status and praise for being on the frontline, to public shaming for the security and remuneration of their position (Collins, 2017). Despite wage cuts, the public service was still viewed as a “privileged group... who drained resources from the rest of society” (Collins, 2017, p. 120). Joyce (2001) described this shift in mentality in government spending from *implicit rationing* to *explicit rationing*. Pre-recession austerity measures were covert and hidden within policy decisions. However, post recession, public services were openly decimated, influenced by the propaganda machine of neoliberalism and claims of improving and streamlining service provision (Joyce, 2001). The austerity measures, not only geared at workers but also at service provision, have become embedded (Joyce, 2001). Few workers are willing to

challenge policies that claim to increase the effectiveness of ‘managed services’ (Kirkpatrick, Ackroyd and Walker, 2005).

Although referring to social work, Rogowski (2015, p. 98) argues that managerialism denigrates the practice from the central role of assessing and meeting the needs of service users “to a narrower, truncated role of rationing ever scarcer resources”. The policy directives of individualised care increased choice, and engagement in the community, which unfortunately costs money (Department of Health and Children, 2006; Department of Health, 2010). In practice, austerity measures reduce choice, limit individual activities and personal time with staff out in the community. Killeen (2014, p. 99) reflects on the impact of reduced spending in the disability sector:

“As time went on and the recession took its toll, and all the budget cuts came about ...Although staff did their best still (whatever staff was left after all the cutbacks), the needs of the service users became bottom of the list...anywhere where money could be saved, it was! Often undoing overnight what may have taken years to set up”.

Social care workers are on the frontline as a witness to the impact of attitudinal changes in wider society towards the disabled, people with an addiction, the homeless and children in care, and the austerity measures that have directly impacted current service provision. Overall, austerity measures have lowered trust in the Government, reduced the morale of public sector workers, and privatisation was identified the least popular of all neoliberal reform (Ong, 2012; Boyle, 2017).

2.4.2 Privatisation

As discussed earlier, the Irish government has a long history of outsourcing the administration and practice of care to religious orders and the voluntary sector (Considine and Dukelow, 2009; Mulkeen, 2016). The administration of social care services has moved from state subsidiarity to state managerialism, from the Church to the 'local' private company (O'Sullivan 2005; Mulkeen, 2016). Since the 1990s, the rationale for the privatisation of care was an assumption that private markets would enhance standards while saving money (Harlow et al., 2012; Cantwell and Power, 2016). Privatisation was viewed as the "private sector "solution" to the public sector "problem" (Dixon, Kouzmin and Korac-Kakabadse, 1998, p. 165) and social care services went up for tender. Government run social care services have experienced a 'hollowing out', with an increase of early retirements, the hiring freeze, reduced numbers, and the curtailed mobility of staff between the existing services (Fanning, 2006; Tronto, 2010; McHugh and Meenan, 2013; Baines and Cunningham, 2015).

Described as a 'race to the bottom' through the competition for tender (Cunningham, 2008), privatisation has reduced the cost, and arguably the quality, of social care services provided by private companies (Ferguson and Lavalette, 2014; Baines and Cunningham, 2015). Through privatisation, the provision of care to those deemed in need is "recast as nonpolitical and nonideological problems", thus requiring only a technical/rational solution to a human problem (Ong, 2012, p.3). Approaching care as non-political downplays the power struggle that is implicit to welfare regimes and care provision (Lane, 2001; O'Sullivan, 2004; Garthwaite, 2011).

In 2009 a ‘Moratorium on Recruitment and Promotions in the Public Service’³³ prevented public services from employing or replacing staff (Department of Finance, 2009; Keohane and Kuhling, 2014). The Government provided an alternative approach for the necessary frontline staff through the policy to “recruit and/or have temporary access to private sector staff” (Department of Public Expenditure and Reform, 2011, p. 20), with the outcome of lowered wages and conditions for staff (Ferguson and Lavalette, 2014; Baines and Cunningham, 2015). Through marketisation, ‘employment agencies’ became the new recruiters of social care workers (Harvey, 2014), with CPL Healthcare and TTM Healthcare as the main providers in Ireland. In 2012, the number of agency workers in Ireland exceeded 50,000³⁴ (Broadline Recruiters, 2012). The salaries and conditions of agency staff, part-time or relief staff are not on par with their public-sector colleagues, for example with the use of zero hour contracts³⁵ (Clarke, 2004; Mulkeen, 2009; Baines and Cunningham, 2015; Mulkeen, 2016). Social care workers have expressed concern over the inability of agency staff to develop relationships with service users (Cantwell and Power, 2016).

“It is accepted that agency staff members and newly recruited staff members may not be best placed to support people with an intellectual disability and/or autism with their intimate care needs given their lack of experience when compared with regular staff member and the lack of opportunity to form trusting relationships with individuals” (Cope Foundation, 2014, p.16).

³³ The moratorium was legislated by the Financial Emergency Measures in The Public Interest (No. 2) Act 2009.

³⁴ Discussed earlier, as the numbers of social care workers are unknown, it is also unclear how many work as agency staff in Ireland.

³⁵ The Working Time Act (1999) enabled zero hour contracts to be used in Ireland, a contract of employment that does not guarantee working hours and workers are not protected from dismissal (Freedland, 2016)

Using agency staff within the disability services is an example where the needs of the budget were prioritised over the needs of the service users (Keogh, 2011). As well as reduced hours and temporary contracts, social care is also impacted by consumerism and the altered service user worker relationship.

2.4.3 Individualism - Service User as Consumer

Gilbert (2009) traces the discourses of disability practices through the ages, starting with the age of the workhouse (1850-1910), the age of the colony (1910-1970), followed by normalisation (1970-1995), concluding that the most recent stage is the age of citizenship, with the change from service user to customer³⁶ and the discourse of choice within cost saving structures. Individualism is a term, used pejoratively to represent the destruction of community and “disintegration of society” (Musschenga, 2001, p. 4) and also positively to represent the ideal personality. For clarity, Musschenga (2001, p. 5) divides the term into two separate entities; *individualisation*, which is the part of individualism that “is an objective process of social change”, and *individuation*, which reflects “the development of personal identity”, that emerges through individualisation. Individualism is central to the age of citizenship, altering the view of the service user, away from being perceived as a vulnerable person in need, to a competent person able to make choices and take care of their own needs (Clarke, 2004b; Lymbery and Postle, 2015; Houston, 2016). The term ‘citizen’ is political, and embedded within this label are the constructs; legitimacy; individuality; the right to be treated equally; to vote and to receive fair treatment from the state (Clarke et al., 2007).

³⁶ These changes were replicated in social care work, ‘client’ was replaced by ‘service user’ (Clarke et al., 2007; McLaughlin, 2009; Harlow et al., 2012).

However, ‘consumer’ is a market-based term, an economic relationship (Juhila, Raitakari and Löfstrand, 2017), centred on the right to choose (Clarke et al., 2007).

This individualist ideology underpins ‘personalised services’ and person-centred planning within the provision of social care services (Musschenga, 2001; Houston, 2016). Person-centred planning is service user friendly, focused on supporting each person or child to plan for their future, it is rights based and challenges the structures that may be limiting the person’s choices and freedoms (Linehan et al., 2014). All individualised policies that promoted increased choice were welcomed by the disability services (Glendinning, 2009). The ‘Direct Payments’ policy introduced in the disability sector is one example of individualisation in action (Department of Health, 2010). With direct payments, individuals receive their allowance which enables them to buy services, for instance, a personal assistant or time in a day service. This is important because it relates to the person’s ability to be a free, independent consumer, and “no action is free from structural influences or the influence of governmental discourse” (Houston, 2016, p. 537). The price for the service user is increased responsibility; for their own problems; for meeting their own needs, and managing the associated risks themselves (Rose, 1998; Roulstone and Morgan, 2009).

Bauman’s (1998) theory on the ‘flawed consumer’ expresses how freedom of choice is limited by the person’s ability to make a choice, which may be difficult for some people engaging with social care services (Galpin and Bates, 2009). Rather than see the failures in welfare provision as based on structural inequalities, individuals are blamed for their over indulgent or feckless actions (Scharff, 2011), responsibility shifts from the state to the person. Individualisation promoted increased choice on “where, how, when and by whom services will be delivered” (Juhila et al., 2017, p.

40), “but fails to grasp the particular nature of the relationship with the worker and the person receiving the service” (Clarke et al., 2007, p. 123). This relationship is central to the service user’s ability to exercise choice because it enables the worker to determine how best to support and empower the person to make their decisions known, and learn, identify and effectively communicate their choices to others (Houston, 2016).

2.4.4 Registration, Neoliberalism and the Deprofessionalisation of Social Care

The statutory registration of social care workers in Ireland has not been a priority in political and policy circles until relatively recently³⁷, and has been driven to a large degree by workers’ self-representation. The first action was the establishment of the Health and Social Care Professionals Council in 2005, commonly known under the title CORU, an adaptation of the Irish word for fair, ‘cóir’. The primary objective of CORU is to protect the ‘vulnerable public’ by establishing Registration Boards for each of the twelve professions covered by the H&SCP Act (2005)³⁸. In 2010, motivated by the promise of imminent registration, the three representational bodies (workers IASCW, educators IASCE, and managers IASCM³⁹) began a process towards unification, and the umbrella body of Social Care Ireland was formed. The

³⁷ In 1973, Pat Brennan wrote to the Department of Education requesting immediate attention for the statutory registration of child care workers (Lyons, 2014).

³⁸ Chiropodists/podiatrists, Clinical biochemists, Dietitians, Medical scientists, Occupational therapists, Orthoptists, Physiotherapists, Speech and language therapists, Psychologists, Radiographers, Social care workers and Social workers.

³⁹ The representative body for workers is the (Irish Association of Social Care Workers) IASCW; for managers - the (Irish Association of Social Care Management) IASCM; and educators - the (Irish Association of Social Care Educators) IASCE.

Social Care Registration Board was established in March 2015 consisting of thirteen members⁴⁰, all volunteering to perform the following duties on behalf of the public;

- “Set the standards that health and social care professionals must meet”.
- “Ensure that the relevant educational bodies deliver qualifications that prepare professionals to provide safe and appropriate care”.
- “Maintain and publish a Register of health and social care professionals who meet our standards”.
- “Ensure that registered professionals keep their skills up to date by promoting continuing professional development”.
- “Establish Fitness to Practise to deal with registrants who do not meet the required standards” (CORU, 2016, np).

The process of creating standards for fitness to practise began with the release of a consultation document on ‘Standards of Proficiency for Social Care Workers’ in March 2016. The final report was published on the 31st of May 2017 (CORU, 2017b). This document presents the minimum threshold standards⁴¹ for entry into the profession after graduation. However, in the context of the apparent ‘professionalisation’ of the sector, the issue of registration is ambivalent for social care workers, as it is not separable from the sociopolitical context of neoliberal ideology.

‘Professionalism’ is often presented as ‘renewed’ through neoliberalism (Hoyle, 2001), that is to say, made more efficient, accountable and transparent. Evans (2008) argues that neoliberalism did nothing to renew ‘professionalism’, but instead de-professionalised (Hughes, 2006) those working within public services. Professions and their role in society have been viewed through many theoretical lenses (Johnson, 1972; Larson, 1977; Dent et al., 2016) in an attempt to define what a profession is, and

⁴⁰ Representing the following; General Public- Damien Courtney, Tim Murphy, Imelda Finnerty, Karen Kieran. Practice-Des Mooney, Dunia Hutchison, Adrian McKenna; Management- James Forbes, Maurice Fenton, Paddy Duggan, Patrick Doyle. The final member is Jim Walsh representing the educators.

⁴¹ A level 7 qualification from an approved programme, 800 hours’ placement under the supervision of registered social care workers.

the ‘truth’ of what constitutes a profession has changed considerably. As noted in Chapter One, Hutchinson (2017) argued that social care in Ireland may not be a ‘profession’ in the Functionalist⁴² sense, maybe because for some workers their title is vague, their role is without legitimate power or status, and they are paid little for their expertise. As Hutchinson (2017, p.1) added social care’s status as a profession “is still contested”. Meanwhile, neoliberalism has altered the relationship between the State and the professional (Lynch, 2014) and metaphorically speaking, thrown the expert out with the bath water, causing feelings of powerlessness, mistrust and deprofessionalisation. Deprofessionalisation is described as a transitional process and over time “professions lose their monopoly over knowledge, their autonomy, the public’s respect, and authority over their clients” (Hyde, Lohan and McDonnell, 2004, p. 238). Accounts of deprofessionalisation of social care focus on a loss of autonomy and increase in bureaucracy (Hoyle and Wallace, 2005; Evans, 2008; Finnerty, 2012), where workers spend more time in the office and away from direct work with others (Harlow, 2003; Kirkpatrick, Ackroyd and Walker, 2005). It is argued further below that the experience of diluted titles and the regulatory process of ‘accounting out’ the social care relationship has also deprofessionalised social care.

2.4.5 Deprofessionalised through Diluted Titles at Home and Abroad

Boscardin and Lashley (2012, p. 38) assert that “without professional titles and roles there would be little need for professional standards”, and that central to having a professional identity is a recognisable title. Of the twenty-six social care workers in

⁴² Functionalists viewed professionals as inherently good, and altruistically protecting society (Carr-Saunders, 1928; Greenwood, 1957).

this study, eleven are defined by their employers by the following titles; project coordinator, senior supervisor, regional manager, facilitator, project worker, case worker, aftercare worker and outreach worker. Although there is a diversity of definitions for social care ‘like’ work internationally, my focus in this chapter is on the relevance of title to practice and the impact of diverse titles on professional identity.

In the United Kingdom, there is a variety of different titles used to define situated care work, for example, the ‘children’s residential support worker’ (children’s homes) and ‘care assistant’ (older service users) (Bullock and McSherry, 2009). The title ‘support worker’ is also applied to workers in disability services, and outreach workers are called ‘family support worker’, ‘key worker’ or ‘project worker’ (Rubin et al., 2016). In Canada, work with children in a residential group home is called ‘child and youth care work’ (Charles and Garfat, 2013), which is closely aligned to the practice of residential care in Ireland. Also in Canada, child and youth care workers are required to have the ‘Bachelor of Arts in Child and Youth Care’, which in most cases is a four-year degree programme (Smith, 2009). Alternatively, workers in disability services in Canada are employed under the following titles; ‘disability support worker’, ‘adult support worker’, ‘community rehabilitation support worker’ or ‘community support worker’, and it is only ‘desirable’ for workers to have the one-year certificate in Disability Support Work (Polzer and Polzer, 2016). Services for homeless people in Canada as with Ireland and the United Kingdom include drop-in shelters, emergency services, and hostels (Guirguis-Younger, Hwang and McNeil, 2014). Common issues for homeless people in North America, Ireland and the UK

include youth homelessness, drug and alcohol addiction, and mental health issues (O'Sullivan, 2004; Seymore, 2013).

Social care work has different titles in France, but the role most relevant to the Irish profession is 'educateurs specialises'. In the rest of Europe, social care equivalent work is commonly referred to as 'social educational work' or 'social pedagogy' (Hallstedt and Högström, 2009), and social care workers as 'social pedagogues' (Europe) (Smith, 2009; Högström, Nilsson, Hallstedt, and Share, 2013). The principles of social pedagogy were discussed in Chapter One, as one of the theoretical lens on the study. As well as social care, social pedagogy is related to the fields of community development, and youth work based on their social and educational ethos, and holistic approach to care (Petrie et al., 2006; Högström et al., 2013). Petrie, Boddy, Cameron, Wigfall and Simon (2006) argue that although similar in ideology and practice, it is a mistake to present 'social care' as a direct translation as it lacks a similar emphasis on education. In finding correlations between social care 'like' professions, Hallstedt and Högström (2009) stressed the importance of understanding each country's current welfare system, and the influence of dominant ideologies on the development of the provision of care, job titles and practices, which in Europe is also the era of neoliberalism.

Returning to Ireland, Williams and Lalor stated in 2001, "a recognised and established job title is surely a prerequisite of informing the public and other professionals of the work carried out by the various types of workers in the social care field" (p. 84). In 1997, the Labour Court recommended ⁴³ a review of practice issues

⁴³ After a ruling by the Labour Court (recommendations 155515 and 17044) in April 1997, the newly formed Department of Health and Children established an Expert Review Board to examine issues relating to ten health and social professionals (Joint Committee on Social Care Professionals, 2002). The ten occupations include: audiologists, biochemists, care workers, chiropodists, dietitians,

related to ten care professions including changing the title ‘child care’ to a more inclusive term ‘social care’ (Joint Committee on Social Care Professionals JCSCP, 2002, p. 2). Despite the Labour Court ruling in 1997 and the recommendations of the Joint Committee on Social Care Professionals (2002), the title ‘social care worker’ was not adopted by all practice settings, especially by child care workers. Twenty years later, the list of titles for those engaged in social care work has increased exponentially. Despite the range of titles still in use, ‘social care’ and ‘social care worker’ are the only titles protected under the Health and Social Care Professionals Act [H&SCP Act] (2005), which when ratified, will restrict any person, social service, or educational institute from using this term without approval. The HSE continues to recruit SCWs under different titles including ‘project worker’, a title which is not protected by their own legislation, the Health and Social Care Professionals Act (2005). Table 2.1 illustrates the range of titles currently in use by the Health Service Executive and non-statutory agencies advertising positions requiring social care graduates. The H&SCP Act (2005) does not decree a responsibility on the HSE to employ only SCWs or other health professionals with the appropriate qualifications.

occupational therapists, orthoptists, physiotherapists, social workers, speech and language therapists were collectively referred to as ‘social care professions’ in the 1997 report (Joint Committee on Social Care Professionals, 2002).

Job Advertisements for Social Care Positions (Transcribed from advertisements on Activelink.ie)				
<i>Date</i>	<i>Title</i>	<i>Organisation</i>	<i>Education -</i>	<i>Salary</i>
27/09/2016	Housing First Project Worker	Simon (Homeless)	Relevant, e.g. Social Care	€27,186 per annum. Linked to HSE Social Care Worker scale.
30/10/2016	Residential Support Worker	The Anne Sullivan Centre for Deafblind	Ideally a Degree in Social Care	No salary or scale listed
27/09/2016	Project Worker	Focus Ireland	3rd level degree in Social Care	No salary or scale listed
27/11/2016	Project Worker	Merchants Quay	Relevant 3rd level social care course	No salary or scale listed

Table 2.1 Diverse Titles for Professional Roles Employing Social Care Workers

As well as a dilution of the profession by the multiple titles used, the Health Service Executive introduced another pay grade under the title ‘social care assistant’, which is a lower paid role. The care assistant salary starts at €5,764 below the social care worker scale (see Table 2.2). This new grade enables services to employ staff qualified to a Quality and Qualifications Ireland QQI level 5, or pay qualified social care workers (educated to QQI levels 7 and 8) at the ‘care assistant’ rate, which may have implications for the registration of social care workers, and this new category of worker. As well as adding complications for registration, this new role ‘the social care assistant’ has further diluted a profession that was beginning to develop a sense of identity and an understanding of the social care work role.

Salary Based on Clause 5.1 of the Lansdowne Road Agreement 1st Of January 2016			
<i>Title</i>	<i>Points on the Scale</i>	<i>First Point</i>	<i>Last Point on Scale</i>
Care Assistant (Intellectual Disability Agencies)	13	24,529	36,680
Trainee Social Care Worker	4	24,567	29,986
Social Care Worker (With Qualification)	12 Plus LSI	30,293	44,306
Social Care Worker (Without Qualification)	11	30,293	43,451
Social Care Leader	7	44,063	51,650
Social Care Manager in Children's Residential Centres	6	53,463	61,321

Table 2.2 Social Care Titles and Pay Scales

Workers without a qualification are paid at the same starting rate as those with a qualification, which suggests that social care education is not valued or recognised within the HSE. Although there are different titles used for social care ‘like’ work internationally, there appears to be cohesion within each country on the use of select titles to identify workers with particular service user groups, which is not the case in Ireland. The chapter continues with the influence of regulation and surveillance on the social care workers experience of practice and professional identity.

2.4.6 Deprofessionalised through Regulation and Surveillance

Regulation was born in Ireland from an ethical desire to protect the vulnerable public from the abuse, and extreme discipline within the Catholic Church run ‘care’ services

(Department of Education, 1970; Buckley, Skehill and O'Sullivan, 1997; Howard, 2014). To ensure that services for children or vulnerable adults were never left unchecked again, the Social Services Inspectorate SSI was established in 1999 (Kneafsey, Murray, Daly and IAYPC, 2010; Vibert, 2011). However, the ethical basis of regulation has become distorted through an audit explosion that has spilt over from the business-like measures of accountability and new managerialism (Power, 1999). Regulation has been reframed, legitimised and embodied within the evaluation 'examination' and surveillance mechanisms of social care work (Foucault, 1977/1995). Regulation encompasses accountability to the service user (Larson, 1977; Share, 2009), discipline and adherence to the ethics of best practice (Black and Wiliam, 2009; Kline and Preston-Shoot, 2012), and being answerable for our actions through a sense of individual responsibility (Bakhtin, 1981). Below, Foucault (1977/1995) highlights how modern societies normalise surveillance and regulation techniques until they are viewed as common sense and woven with the self and social body of the worker.

“Our society is one not of spectacle, but of surveillance... it is not that the beautiful totality of the individual is amputated, repressed, altered by our social order, it is rather that the individual is carefully fabricated in it, according to a whole technique of forces and bodies” (Foucault, 1977/1995, p. 217).

Since 2007, social care services are regulated through the Health Information and Quality Authority HIQA (Department of Health, 2007). The inspections, planned or unplanned, aim to monitor the compliance of a service to agreed codes of practice and assess the impact of a change in the service (Department of Health and Children, 2001; HIQA; 2008; 2012; 2013; 2014). As a system of regulation these reports are productive (Foucault, 1977/1995), and they influence, control and correct the behaviour of others, the workers and the service (Lea, 2017). However, there is limited

research on the impact of HIQA inspections on the lived experience of the social care worker, or on positive evidence-based practice (Molloy, 2014). It is common for staff to underreport examples of good practice, as excessive workloads and staff shortages limit the time available to write (Molloy, 2014). Within the regulation process, the quality assurance and new managerialism approach (Biesta, 2004) altered the perception and recording of ‘outcomes’, including which ones are valued, and by whom. What constitutes an ‘outcome’ from an individual service user’s perspective is difficult to measure (Wren, 2003; Kline and Preston-Shoot, 2012), and sometimes not evident until years after the person has left the service. Social care workers tend to welcome regulation and accountability, but it is the type of accountability that is in question. The impact of neoliberalism on the social care relationship has broader implications (Moore, 2007), where the central role of learning has become devalued. There is a “reconstruction of social relationships on the basis of competition and efficiency”, and the shared activity of engaging in a relationship within social care is now viewed as “inputs or products, whose value has to be demonstrated on the basis of quantitative and standardised measures” (De Lissovoy, 2013, p. 423).

As well as increased regulation, recording and surveillance through HIQA, the Health and Social Care Professionals Act (2005) has provided the legislative framework for the development of a ‘super regulator’, with the power to control who can access the profession, and how they must behave (Department of Health and Children, 2005; Mills, Ryan, McDowell and Burke, 2011). As stated earlier, social care workers and education programmes will be regulated through the statutory registration process. Raising the bar for entry, rather than the standards of practice, regulation, in practice, may do nothing more than protect the title and access to the

profession (Walton, 1998). Although there is an increase in the number of professions becoming regulated through statutory registration in Ireland, the country is far behind Canada and the United Kingdom (Mills et al., 2011). Mowbray (1999) and Clark (2003) argue that there is limited evidence to suggest that service users are more protected within regulated professions, in fact, they may become more vulnerable because of “the false assumption that safety had already been assured” (Mowbray, 1999 p. 212).

2.4.7 Summary

Social care is vulnerable to changes in policy, and the most influential are privatisation and marketisation of care, increased regulations, and the rationing of resources through austerity measures. These policy decisions, presented under the auspices of increased transparency and accountability have become subsumed, normalised and reinforced by the neoliberal workers (Foucault, 1977/1995). In social care work, medical/scientific opinions and judgements are respected and valued over others, and any scientific/rational tasks that can be measured are valued as the desired outcome of care (Foucault, 1977/1995). Austerity measures of neoliberalism affected all social care services, who were depleted in both fiscal and human resources (Keohane and Kuhling, 2014). Rationalised as a private solution to a public problem, private care agencies entered the care market, described as creating a race to the bottom (Cunningham, 2008) in service provision and conditions for social care staff. During this age of citizenship (Gilbert, 2009), power relations have shifted from a needs based service user, to an individualised and able consumer (Houston, 2016). These policies use the language of freedom by including the terms of ‘increased choice’, ‘engagement

in community’ and ‘empowerment’, which may in fact only paper over ineffective policies that reduce choices and disempower service users.

This section also noted the deprofessionalisation of social care through diluted titles and the introduction of a lower grade but similarly titled social care assistant. Finally, workers may resist in tacit and overt ways by engaging the complexity of their work, questioning their subjection as neoliberal workers, and arguing for more time to spend with the service user. The chapter continues with an overview of the evolution of social care education in Ireland from an ideology of training for care, to the graduation of students as an end product under a neoliberal approach.

2.5 Social Care Education: from Care to Commodification

As noted in Chapter One, and in relation to the social pedagogical emphasis in wider Europe discussed in section 2.4, this study regards learning as central to the social care relationship. This section discusses the formal learning contexts of social care in Ireland and analyses how learning to ‘do’ social care has developed and been framed under the ideological shifts brought about by state-church and state-market relations.

A recognised social care qualification was identified as a requirement for statutory registration and access to a professional identity (CORU, 2017b). Social care education in Ireland began in 1971 with a single course providing training for religious orders and lay people in how to care for children in residential care (Lyons, 2014). Today, social care education is provided by a patchwork of commodified institutions (Lynch, Grummell and Devine, 2012) with students viewed as products, disconnected from the services they will ultimately work in. From humble beginnings in Kilkenny

in 1971, social care programmes have become absorbed into the vast landscapes of educational institutions throughout Ireland and are now provided by 18 separate colleges. Changes to third level education from neoliberalism and the administrative structures of new managerialism (Lynch, Grummell and Devine, 2012), have impacted how social care students are trained and perceived.

2.5.1 History of Social Care Education

Social care education emerged historically from an urgent need to protect vulnerable members of the public, in particular children within institutional care (Share and Lalor, 2009; Lalor and Share, 2013). The negligent and abusive practice outlined in the 1970 ‘Reformatory and Industrial Schools Systems Report’ (Kennedy Report)⁴⁴ was explained in part by “the lack of professional training in child care”, warning that the education of child care workers should “take precedence over any other recommendation” (Department of Education, 1970, pp. 13-14). All child care workers were tarnished with this negative press, and morale within the profession was low. Inspired by the Kennedy Report (1970), Sr. Stanislaus Kennedy and Bishop Peter Birch established a course in Kilkenny, recruiting Pat Brennan to join the teaching team. The course ran for ten years (1971-1981) and was unique in that students learned to understand the lives of people through the time they spent living together in the residential part of the programme (Lyons, 2013). While the Kilkenny course was in its infancy, the NCEA was established to confer degrees, diplomas and certificates for

⁴⁴ The Reformatory and Industrial Schools Systems Report (1970) is the product of an inquiry led by District Justice Eileen Kennedy into the care of children. This report, known as the Kennedy Report, recommended the deinstitutionalisation of children in care (Department of Education, 1970; Howard, 2014).

students in non-university third level institutes (Irish Times, 1972), including child care. The regulatory structure of the National Council for Educational Awards (NCEA) and the bureaucratic mechanism of the Department of Health and Children influenced the merger between diverse helping professions under one umbrella ‘social care’ (Courtney, 2012). Discussed earlier, the title ‘social care’ was not welcomed by all helping professionals (McElwee and Garfat, 2003), especially child care workers, who saw the move as meeting the needs of the bureaucratic administration rather than a purposeful and appropriate merger for the workers of similar practices.

These technical colleges, established under the Vocational Educational Act of 1930, provided education “pertaining to trades, manufactures, commerce and other industrial pursuits, including science and art, and physical training” (Coolahan, 1981, p. 99-100). Although the remit for the technical college was continuing education as well as technical education, child care, without a clear alignment to a technical discipline, was first housed in School of Domestic Science, at Cathal Brugha Street (Duff, Hegarty and Hussey, 2000). The first child care award⁴⁵ accredited by the NCEA in the Dublin Institute of Technology in 1974, was followed shortly by the National Diploma in Child Care at the Waterford Regional Technical College [RTC] (Lyons, 2013). The next child care course was established in Sligo RTC to train prison wardens from Loughan House Juvenile Detention Centre for boys (Reilly, 2008). Cork, Athlone and Galway followed suit, increasing the number of child care courses to six by 1991. Table 2.3 lists the programme titles offered by the eighteen providers.

⁴⁵ Diploma in Child Care

Educational Institute	Award / Programme
Dublin IT/Cork IT /Tralee IT / Dundalk IT / NUI Galway	BA in Social Care
Blanchardstown IT/ Waterford IT /Athlone IT/ Carlow College	BA in Applied Social Studies in Social Care
Limerick IT	BA in Social Care Work
Sligo IT / Athlone IT / Tallaght IT	BA in Social Care Practice
Galway-Mayo IT	BA in Applied Social Care.
Open Training College	BA in Professional Social Care (Disability)
Carlow IT	BA in Applied Social Studies – Professional Social Care
Letterkenny IT	BA in Health and Social Care
Dublin Business School	BA in Social Studies

Table 2.3 List of Programmes Titles for Social Care Programmes 2016 -2017

The Open Training College launched a national diploma in 1992 specifically for workers in the disability sector. In 2001, the NCEA was replaced by the Higher Education Training Awards Council HETAC and the terms *social care* and *applied social studies* replaced *child care* in the accredited programmes (Joint Committee on Social Care Professionals, 2002). In 2002, applied social studies /social care programmes were offered by Tralee Institute of Technology [IT]; Blanchardstown IT, and Dundalk IT in 2003, followed shortly by Carlow IT in 2006 (main campus and Wexford campus). NUI Galway was providing part-time social care programmes from 1993, which developed into the Bachelor of Arts (Social Care) in 2008. The final courses to emerge were Letterkenny IT in 2008, Galway-Mayo IT in 2009, and the Dublin Business School bringing the total to eighteen providers at the time of publication.

2.5.2 Disconnected from Practice

This thesis argues that social care education has become disconnected from practice; due to increased student numbers; a reduction in personal and self-awareness training; the treatment of social care as another ‘technical’ programme; the limited number of social care qualified lecturing staff and the academic inflation of their programmes. It is important to note that social care education was instrumental to the diversification of social care into a variety of services. As the Kilkenny programme is where social care education began, the following vignette is from two recorded conversations I had with Pat Brennan (March 2014), and three past pupils from the Kilkenny programme (May 2014), as they spoke about the first child care course⁴⁶. Originally, social care education aimed “to overcome deprivation they [the children in residential care] must be given love, affection, and security by those in whose care they are placed” (Department of Education, 1970, p. iv), and thus Pat Brennan and Sr. Stanislaus Kennedy designed the course to develop the holistic worker, who is able to love and care for self and other. Figure 2.1 presents a vignette from an interview with Pat Brennan and three past pupils on the main aims of the original programme.

⁴⁶ The original focus of this study was to identify the gap between social care education and practice and Pat Brennan and three of his past pupils were interviewed about the first social care programme. Although the focus of this study shifted, a vignette from those interviews is included here to emphasise the evolution of social care education away from relationship based practice.

In Conversation with Pat Brennan

Pat: *“What is the task of social care? I don’t think Ireland has addressed this. Social care is a professional qualification not an academic qualification, the task is to train a cohort to work with very disturbed children and young people who cannot cope with the intimacies of family. Educators need to construct a containing and learning space where the adult workers in training are sophisticated, firstly, in their understanding of themselves, and on top of that then, they can question and support the child to understand themselves”.*

In Conversation with Three Past Pupils of the Kilkenny Programme

“The focus was of gaining experience through placement and learning about the self through experiential group work. The [experiential] group was aimed at forcing you as an individual, to be reflective on the self, and your relationships with the other people on the course, and the implications of this on your life. People formed personal relationships with love, generosity and conflict, with nowhere to hide. The most important thing of the course was to look at the self and there was no hiding the self, from the self. The course promoted an honesty in saying how you feel out to the group, it was an intense personal experience and this bonded people together”.

Figure 2.1 Conversation with Pat Brennan and Three Past Pupils (Recorded and published here with permission, 2014).

The level of personal development training on the course was never repeated, which was viewed by Kennefick (2003, 2006) as a deficit in the National Council for Educational Awards (NCEA) child care programs (Lyons, 2009).

Somewhere along the journey, social care education shifted focus from providing quality training for people working with vulnerable children and adults, to meeting the needs of a consumer, the ever growing student population in Ireland (Department of Education and Skills, 2015). The ‘National Strategy for Higher Education to 2030’ (Department of Children and Youth Affairs, 2011) describes how the higher-level landscape must change to meet the developing social, economic, and industrial needs of society. The report highlights the importance of growth in student numbers in all sectors through direct entry and mature students, both nationally and

from abroad (Department of Education and Skills, 2015). Social care programmes are considered by the same standards as any other programme delivered by the QQI. Although some colleges have introduced measures to assess the suitability of prospective students to the programme, this approach is inconsistent.

Throughout the years, individual concerns were raised over the future (O'Doherty, 2003) and relevance (Williams and Lalor, 2001) of social care education (O'Doherty, 2003) because of its inability to foster a 'social care identity' (Hallstedt and Högström, 2009; O'Connor, 2009) based on the increased numbers in social care education classes (Lalor, 2009; O'Connor, 2009; Lyons, 2013). The largest obstacle for best practice within social care education is the rise in student numbers, and this is contributing to the disconnect between practice and education. The original programme (Kilkenny 1971-1981) restricted numbers, and class sizes varied each year, but never went above twenty. Social care programmes throughout Ireland vary, with some programmes limiting numbers to 50, and others have a student intake above 150 (Courtney, 2012). As the numbers in social care increased (courses and students), the application process was passed to the Central Applications Office CAO to administer direct entry students. Prospective students had direct entry to a social care programme through the CAO process which does not assess their suitability to the profession of social care. At the 2016 Social Care Ireland Conference, Ginny Hanrahan stated she was familiar with high student numbers and unlimited access to the programmes and was in favour of interviewing prospective students in line with social work policies, however, interviewing was not listed within the criteria for entry (CORU, 2017a).

Williams and Lalor (2001, p. 86) note that “some commentators have expressed doubts as to whether social care courses are providing workers with the essential skills required”. This argument is based on the claim that social care education is too generic and does not train workers for fitness to practise in a specific setting (CORU, 2012; Lyons, 2014). Although all social care programmes outlined in Table 2.3 adhere to the performance strategy (Doherty, Horne and Wootton, 2014) of the Quality and Qualifications [QQI] ‘Award Standards - Social Care Work’ (QQI, 2014). Nonetheless, each programme differs regarding the structure and module composition, and the Institute's understanding of social care influenced to a degree by the experience and educational background of the lecturing team. Traditionally, social care institutes of education employed social workers to teach the practice elements of the course. Current social care education in Ireland is provided by a diverse and specialised lecturing team which may include; social care workers, social workers, psychologists, social policy or sociology lecturers, legal professionals and in some cases art, music and drama teachers for the creative modules. This list is not exhaustive of all the different professions that may be involved in the current provision of social care education.

Central to statutory registration is the approval and regulation of all social care education programmes. Social care education will have to meet the standards outlined by CORU (2017a), in order to receive approval to continue educating social care workers. The Social Care Registration Board, when established, has ultimate power over the educational institutes providing social care education. Institutes of Technology will have to satisfy the Board that the public will be protected, as indicated in sections 7, 27 and 38 of the 2005 Act, through the delivery of a “high standard of

professional education”. Colleges will have to prove they have suitably trained the designated professional to be a “fit and proper person, able to engage in the practice of the profession, with knowledge of the language necessary for practice” (Department of Health and Children, 2005, p. 11-28). The Social Care Registration Board, in line with the standards of CORU, have outlined that only educators eligible to register on the social care registration board will be permitted to teach or supervise the practice component or the theory of practice elements of the social care course. This will cause difficulties for the existing social care course boards due to the limited number of social care workers employed in education. Educators are therefore gatekeepers (Devitt, Kerin, and O’Sullivan, 2012), with a shared responsibility to protect vulnerable members of the public, by ensuring that those graduates are fit and proper persons, are educated by social care workers, in small groups with a focus on the holistic development of the student.

2.6 Conclusion

This chapter provides a sociopolitical analysis of Ireland’s complex and disjointed development, which demonstrated that church voluntarism, a patriarchal construct of women’s role in the home, and a welfare ideology of the deserving and undeserving poor has guided the diversification of services for vulnerable people in society. Ireland’s approach to care in these diversified services is based on the neoliberal agenda, which aims to privatise care and minimise the importance of the relational role of the social care worker. Neoliberal ideology is also evident in the disconnection of social care education from practice which may inhibit the potential ‘fitness to

purpose' of many programmes for approval by the Registration Board (CORU, 2017a).

This chapter also stresses the issue of the deprofessionalisation of workers based on the privatisation of care services, external accountability measures that mean little to people on the ground, the problem of multiple titles and the expansion of professional qualifications. Despite budgetary cutbacks, workers balance being accountable to the regulatory structures with an accountability to the service user (Desai, 1998; Harlow, 2003; Lynch, 2012). Social care has experienced the multiple forces and residual ideologies of patriarchy and voluntarism, and new managerialism's dominant and emergent mechanisms of regulation, marketisation, consumerism and austerity. Social care practitioners and educators are also deciphering the complex dilemma ridden nature of professional knowledge, and proficiency located systems of regulation. With these issues of power, ideology and social change introduced, the next chapter focuses on understanding the three themes of social care; practice, identity and context.

Chapter Three Contesting and Living Social Care: Practice, Identity and Context

3.1 Introduction

The chapter is structured under the three main themes; social care practice, worker identity, and context, supported by a social care ‘body of knowledge’ from the ‘inside out’ (Fewster, 2013). Given the focus on practice, in particular, the chapter first begins with an exploration of official and scholarly perspectives on social care practice. It particularly examines contemporary scholarly views regarding situated knowledge through regimes of competence and the embodiment of practice through a social pedagogical/child and youth care lens of ‘head, heart and hands’, which incorporates the contemporary theorists from practice in Ireland, Scotland and Canada (Doyle and Lalor, 2009, 2013; Smith, 2009, 2012; Garfat, 2008, 2012; Digney and Smart, 2014).

In later chapters, I consider how these understandings explain social care workers’ experiences, which may inform and/or contest the official redefinition of social care under the CORU standards of proficiency (CORU, 2017b). The discussion on practice concludes with a clarification that practice is experienced through the relationship as situated, embodied, holistic, challenging, sometimes painful and ultimately the centre of it all. Under the second theme of identity, workers are presented as motivated to help, who communicate the identities they have claimed through story (Garfat, 2008; Sfard and Prusak, 2005), and are continually learning in practice. The context is defined as figured within physical spaces and places, used for purposeful practice, and presented as a home, away from home. The chapter begins by exploring how the practice of social care is becoming officially defined in Ireland.

3.2 How Social Care Practice is Becoming Defined in Ireland

As acknowledged in Chapter One, social care is difficult to succinctly define, beyond to accept the work as a partnership with marginalised people in diverse settings (Health and Social Care Professional Council, 2011). Chapter Two established that social care is also political and shaped by dominant ideologies of neoliberalism, new managerialism and medical approaches to care. Social care emerged from a bureaucratic decision to train workers from the disability sector alongside residential child care workers, under the generic title social care. As the number of courses grew social care students were placed in other settings, and gradually they began to gain employment there. Slowly the social care programme became a recognised qualification for employees in a multitude of settings, and the diversification of social care began. As discussed, the Social Care Registration Board are in the process of defining these workers, and the first step in the process was the publication of the ‘Standards of Proficiency’ in May 2017.

3.2.1 Defining Social Care Practice Officially by Standards of Proficiency

As part of the registration process for social care, workers will be deemed fit for practise if they have achieved the required *standards of proficiency* - which are described by CORU as *threshold standards*⁴⁷. CORU was assigned the task from the H&SC Act (2005) to establish the criteria for all twelve constituent professions. CORU designed the standards of proficiency to include five domains, and the first four (professional autonomy and accountability; communication, collaborative practice

⁴⁷ The minimum standards the graduate must possess on entry to the registry.

and teamworking; safety and quality, and professional development) were deemed generic and the general guidelines for all twelve professions. However, domain five is described as profession specific (CORU, 2017a) and adjusted to suit each discipline. It is important to note that the standards of proficiency for social care are now the fixed standards for social care workers. The statements on social care from the fifth domain are reviewed here in light of their theoretical origin and/or leaning, which may influence the future direction of social care practice, and also provide an insight into the power relations at play (Foucault, 1977/1995). The following points are direct statements from the ‘Professional Knowledge and Skills’ (Domain 5) of the standards of proficiency for SCWs (CORU, 2017b, pp. 9-10). They are grouped here in order of their relationship to each other, rather than chronologically.

1. “Know, understand and apply the key concepts of the domains of knowledge which are relevant to the profession”.
6. “Demonstrate skills in evidence-informed practice, including an understanding of competing theories, concepts and frameworks underpinning social care work and demonstrate an ability to apply the appropriate method in professional practice”.
14. “Be able to identify and understand the impact of social care history, organisational, community and societal structures, systems and culture on social care provision”.
16. “Understand the role of, and be able to demonstrate skills in the use of creative and recreational interventions in social care work to meet the needs of the service user in a variety of contexts”.

Points 1, 6, 14 and 16 are general statements that will allow for the development of mentalities of social care to emerge, defined as ‘evidence-informed’, a term commonly used in social work as a way of reducing the practice-knowledge gap (Kelly, Raines, Stone and Frey, 2010). There is an acknowledgement here that graduates will need to

know competing practice theories, enabling them to choose from a range of responses for each experience they encounter.

2. “Understand and be able to apply principles of social justice in one’s work including being able to challenge negative discrimination and unjust policies and practices; demonstrate an understanding of cultural competence, and work towards social inclusion”.
3. “Understand and apply a ‘human rights based approach’ (HRBA) to one’s work including the promotion of the service user’s participation in their own care; ensure clear accountability; apply principles of non-discrimination; support other staff members to empower service users to realise their rights; be aware of the legality of actions within a service including the need to comply with any relevant legislative requirements including adhering to human rights obligations”.

Social justice, a term originating with Aristotle, is presented as a critique of ineffective bureaucracies (Harvey, 2005), and the justification for organised protests against inequality. Point 3 is also political, by describing social care as a ‘human rights based’ approach is a shift in mentality from a ‘charity’ or ‘needs’ based model, which is present in the current definitions of practice (Lalor and Doyle, 2013; Share and Lalor, 2013). Service users’ *rights* are defined as entitlements, and the emphasis has moved from meeting needs to recognising rights, and empowering service users to claim them (Novak and Adams, 2015). HRBA offers “an opportunity to reflect more broadly on the power dynamics inherent in the practice” and help wrestle “back notions like ‘participation’ and ‘empowerment’ from neoliberal instrumentations” (Nyamu-Musembi and Cornwall, 2004, pp. 3, 4). By advocating HRBA, CORU as a statutory agency is advocating for social care workers to value rights at the heart of their practice, and challenge policy makers to be accountable, “rights imply duties and duties demand accountability” (Office of the United Nations High Commissioner for Human Rights, 2002, p. 5; Edwards, 2017).

4. “Demonstrate a critical understanding of relevant biological sciences, human development, social and behavioural sciences and other related sciences, together with a knowledge of health and well-being, disease, disorder and dysfunction relevant to the role of social care worker”.
7. “Demonstrate an understanding of the theories of individual and social development across the lifespan and contexts and within different cultures including the knowledge required to work with individuals, children, vulnerable adults, families and marginalised groups”.
10. “Be able to identify, interpret, record and respond appropriately to patterns of behaviours displayed by service users in a variety of settings”.
11. “Be able to analyse activity and adapt environments to enhance participation and engagement in meaningful life experiences and positively influence the health, well-being and function of individuals, families, groups and communities in their everyday activities, roles and lives”.

The key concepts of human development, social and lifespan development are threaded through social care literature (Lalor and Share, 2013), evident from points 4, 7, 10 and 11. They are also reflective of the increasing role of psychological interventions in social care practice, as many social care workers are required to follow strict behavioural support plans without question. However, I was unable to encounter the origin of ‘biological science’ or knowledge of diseases, within the epistemology of social care. As such, these requirements may be a remnant of the generic CORU framework, and evidence of a normalised hierarchy favouring medical expertise.

8. “Understand the role and purpose of building and maintaining relationships as a tool in the delivery of social care across the lifespan in a variety of contexts”.
9. “Have a critical understanding of the dynamics of relationships between social care workers and service users and the concepts of transference and counter-transference”.

It is worthy of note that the relationship in points 8 and 9, is presented as a tool and a role, which needs to be built and maintained. It was also unusual to see the concepts ‘transference and counter-transference’, defined within a social care relationship when they are the commonly cited processes within the therapeutic relationship of psychotherapy (Wiener, 2009).

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

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

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

18. “Know the basic principles of effective teaching and learning, mentoring and supervision”.

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

Points 12 through to 19 are recognisable as common discourse with social care literature and education (Share and Lalor, 2013; Howard and Lyons, 2014; QQI, 2014; SCI, 2016). Interestingly, point 18 has an educational focus which may invite a more social pedagogical approach to social care in the future. On a final note, points 5 and 17 relate to the SCWs ability to engage in social care research. However, most social care programmes are structured with the research component in the fourth year of a level 8 (honours degree) programme, which is above the qualification required for registration (level 7).

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

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

The standards of proficiency framework was accompanied by the criteria for education which provides details on how the standards of proficiency will be achieved, including; practice placements, admission details, programme management, curriculum and assessment strategy (CORU, 2017a). Post-registration, all social care

practice in every context deemed as engaging in social care work will be defined by these ‘standards of proficiency’ (CORU, 2017b) but the knowledge underpinning these fixed standards⁴⁸ is still open to interpretation and contestation by the stakeholders which includes workers, managers, educators, SUs and the general public (CORU, 2017b). The question posed by Hanrahan (2009) asking ‘what do social care workers do’, needs to be understood in relation to these apparently fixed, somewhat abstract standards by which the workers practising social care will be measured. As discussed earlier, the question is further complicated by the fact that social care workers are situated within diverse settings that may ultimately dilute social care beyond identifiable common standards of proficiency. The following conceptual lenses on practice are discussed below for their potential contribution to understanding social care practice in more complex situated ways through the regimes of competence; liminal situations; social pedagogy/relational child and youth care metaphor of head, heart, hands, and relationship based practice.

3.2.2 Practice as Situated, Shared and Indigenous Enterprises

Wenger (1998, p. 137) states that workers in a specific community of practice are in the pursuit of ‘enterprises’, (goals, ways of workers, specific roles, skills and tasks) established over time, and negotiated through the ‘regime of competence’. Enterprises are not individual skills or traits, which some person can own, they are “experienced and manifested” through negotiation, mutual engagement and accountability (Wenger,

⁴⁸ The Standards of Proficiency for Social Care has undergone a public consultation process, and the published standards are fixed and protected under the 2005 H&SCPs Act. However, each standard is broad which enables some flexibility in the interpretation of the standard by the approved programme.

1998, p. 137). The main three themes of ‘regimes of competence’ include; joint enterprise, shared repertoire and mutual engagement, illustrated in Figure 3.1.

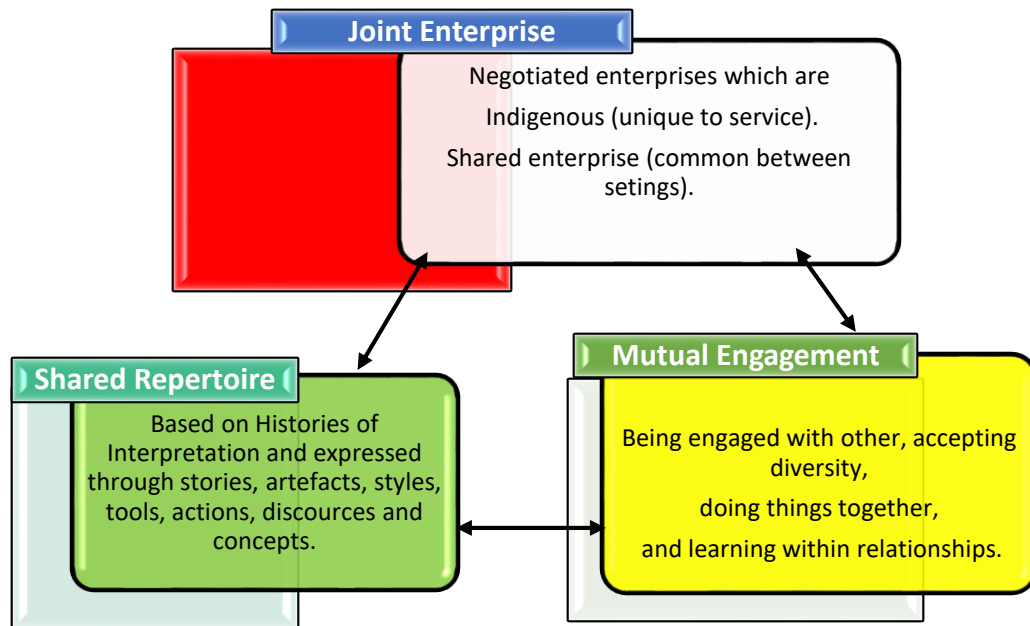


Figure 3.1 Regimes of Competence (adapted from Wenger, 1998, p. 73).

Social care workers learn, through negotiation and engagement (mutual engagement) with others in a specific setting, the shared meanings (shared repertoire) of practice and identity, their ways of doing things, or making decisions, and being in the setting (Lave and Wenger, 1991; Wenger, 1998; 2010). This ‘regime of competence’ (Wenger, 1998) develops over time, as the worker learns how to be and act in the different situations they encounter.

Workers learn the ‘indigenous enterprises’, or “local ways” of working from spending time with others and being mutually engaged in activities (Wenger, 1998, p. 80). Indigenous enterprises are unique to the service, experienced and learned through day-to-day practice in a specific service. Wenger (1998, p. 85) asserts that the “indigenous production of practice”, may be the organisation’s strength and also its

weakness, as communities may reproduce poor practice as well as good. Wenger (1998) explained regimes of competence, using the example of a claims office. The workers exerted control over their own practice through local or indigenous ways of working, however, “their job is part of a large industry”, with which they are “interconnected”, through the pursuit of shared enterprises (Wenger, 1998, p. 79).

The shared enterprises of social care may relate to the organisational policies that are utilised by different independent services within one larger organisation. For example, working in one of the 66 residential homes that belong to St. Michael’s House services, although “each house is run independently”, they all adhere to the policies and practices developed by the organisation (St. Michael’s House, 2017, np). Shared enterprises may also relate to the practices that workers share between different services. As social care workers gain experience in different settings, either through placement or by gaining employment in diverse organisations, they influence the decision making and culture of the new service, through engagement and negotiation (Wenger, 1998). It is possible that some of the negotiated enterprises are shared or common to the social care worker, irrespective of the setting. The regimes of competence framework is relevant to a study of social care practice in different contexts, not to establish the existence of a community of practice within each setting, but to examine if the knowledge gained through the situated systems of negotiation, participation and reification (Lave and Wenger, 1991, Wenger, 1998) serve to dilute social care as a cohesive profession, or can highlight the shared practice between different contexts. The chapter continues within situated learning where the worker is negotiating decisions or experiences they find challenging, called liminal situations (Turner, 1969).

3.2.2.1 Practice as Liminal Situations

Anthropologist Victor Turner (1969) explored the characteristics of Arnold van Gennep's (1908/2004) 'rites of passage', to explain the middle or liminal phase of all transitional stages. There are three dimensions or variations to liminality; the subject, space and time (Thomassen, 2014), and all three are relevant to social care. Turner (1969) provided a list of 'liminal situations' that relate to subjects (individuals or groups), temporal states (can occur for a moment or over a longer time period), and spatial (an in-between space). Social care workers can experience these liminal situations as resistance.

Social care workers are compelled to resist in certain ways, for example, when increased regulation directs their time and energy towards scientific/rational activities and away from direct care with the SU (Parton, 1999). This is also reflected in the rational-scientific structures and procedures of regulatory bodies that define the lived experience through outcome measures and tick charts, of codes, registers and classifications (Foucault, 1977/1995), which do not reflect real day-to-day messy practice. This dichotomy places the worker within a liminal situation. "Real-world problems do not come well-formed but on the contrary, present themselves as messy and indeterminate. Knowing in such situations is tacit and implicit" (Parton, 2000, p. 453), and thus worker's resistance is within the liminal space.

Workers also encounter a liminal situation when the experience causes them to return, temporarily to the status of novice (Turner, 1969), being unsure what to do next. Within this liminal phase, the worker is betwixt and between states, and through the *rituals of status elevations* [original emphasis] (Turner, 1969, p. 167) the worker moves from novice to oldtimer (Wenger, 1998), through resistance, making decisions

and taking risks. Workers are caught ‘betwixt and between’ being subsumed within and part of the system that controls, and becoming aware of being controlled (Turner, 1969; Foucault, 1977/1995). It is “the question of what is it for real people to reject or refuse, or on the other hand in some manner to consent to, acquiesce in, or accept the subjection of themselves or of others” (Foucault, 1977/1980a, p. 267). In social care practice, it is easier to acknowledge and accept the existence of the ‘unknown space’ occupied by the service user, than to accept this position as a worker. The following vignette from Garfat (2004) uses the metaphor of two people learning the steps to a dance, the ‘dance of the unknowns’, which is new to both of them and captures the experience of being betwixt and between this liminal situation, the unknown space of practice.

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

This unknown space is presented as a normal stage of relationship development in relational child and youth care, the exploring ‘safe uncertainty’ stage (Featherstone, White and Morris, 2014). Within the dance of care, the worker negotiates through the liminal situations, when they transition from novice to professional while being genuine, human and present.

Liminal situations can also include feelings outside the boundaries of acceptable discourse in the time or space (Thomassen, 2014), which is also relevant to social care. For example, workers may sometimes feel ‘less loving’ or have negative feelings about doing social care work with others, especially if the service user is violent towards them (Burton, 2015). Some workers are afraid to express these feelings from fear of being viewed as the ‘bad worker’ (Lyons, 2013) or being dismissed from the service (Burton, 2015). Taylor (2011) argued for support groups to provide a safe space for workers to discuss the impact on emotional work on their life and enable them to answer the challenging questions, and not bring the emotional baggage home. Also, support in the form of professional supervision from a line manager may be viewed as a mechanism of discipline rather than a safe space (Doyle, 2014). The chapter continues by exploring the role of the relationship in social care like disciplines; social pedagogy and social work in the UK, child and youth care in Canada (Doane, 2002; Trevithick, 2003; Garfat, 2008; Ruch, 2010).

3.2.3 The Relationship is Embodied and Holistic Practice

Scholarly discourses on the relationship in social work, social pedagogy and child and youth care (Garfat, 2003, 2008; Stephens, 2013; Egan, 2014) have influenced social care workers and educators in Ireland (McHugh and Meenan, 2009, 2013; Lyons, 2009, 2013, 2014; Digney and Smart, 2014). The various relationship approaches may differ slightly in position and context, but all involve one person engaging with another, while they are doing things together and being with each other. We provide care and meet needs through the relationship (McHugh and Meenan, 2009, 2013; Burton, 2015), using our personality, our self, and our relationship skills from the

social care worker's toolbox (Lyons, 2013). The relationship between a worker and service user is meaningful (Digney and Smart, 2014), and trusting (Ruch, Ward and Turney, 2010; Howard and Lyons, 2014). The relationship is the 'core' to this practice (Kennefick, 2006; Lyons, 2009; Cameron and Moss, 2011; Brennan, 2012; Charles and Garfat, 2013; Lyons, 2013; Behan, 2014; Howard and Lyons, 2014; Mulville, 2014).

Garfat theorised this experience of being in a relationship with others through the terms, 'hanging out', spending time doing 'normal' things together, 'hanging in' and 'counselling on the go' (Garfat and Fulcher, 2012). Hanging out is an important concept because it provides a language for the purposeful use of sharing time together for social care practice. 'Hanging in' reflects the commitment to care (Gompf, 2003) that is the responsibility of every social care worker, which takes time and patience (Garfat and Fulcher, 2012; Digney and Smart, 2014). 'Counselling on the go' is based on the potential of service users to share painful memories and experiences with their key-worker, while they spend time together (Mann-Feder, 2011). Through hanging in, hanging out and counselling on the go, the social care workers learn the likes, dislikes and needs of the service user, in order to communicate and advocate. Using the relationship in this way enables workers to act as a bridge between the service user and the other professionals, where social care workers can effectively advocate and communicate these needs. The relationship is what makes social care work distinct; it is the most important learning space in their practice. Child and Youth Care has embraced 'relational practice', described as going beyond the 'doing' of practice, and more about 'being' and feeling (Doane, 2002; Garfat, 2008).

Social pedagogues also define the relationship in their practice as holistic and embodied, a mutual collaboration between the worker and service user, centring on being supportive, and working within the relationship (Cameron and Moss, 2011). Johnson (1987) described embodiment as involving the whole body in meaning making within practice. Social care work is embodied through the lived experience, decision making, and all the movements and practices within the regimes of competence (Wenger, 1998). “A movement is learned when the body has understood it, that is when it has incorporated it into its world” (Merleau-Ponty, 2012, p. 139), through the lived experience of day-to-day practice. Social care workers have ‘a body’ (Johnson, 1987) “through which [they] act in the world” of practice (Merleau-Ponty, 2012, p. 140). Workers also have a mind which is engaged in being present and thinking about how to care for the person and hands used in physically supporting them to meet their needs. Embodiment for social care workers is not just about the engagement of the body, the thoughts and feelings connected to practice, but the overall experience of being in the world.

Figure 3.2 is an example of being embodied in the physical space of others. The drawing represents a scenario from my practice when I was trying to get to know the young people, through the deliberate practice of ‘hanging out’ (Digney and Smart, 2014) and spending time with them in this shared space. However, I did not know where to ‘sit or ‘stand’, or how to be with the young people in the space, so I stood in front of the TV screen and offered to make tea.



Figure 3.2 Not Knowing Where to Stand (Source: Pencil Drawing by Denise Lyons)

Embodiment in social care practice is aided through the relationship, as we need to know people well in order for them to be comfortable with us, physically, emotionally and cognitively. Social care practice is the embodiment of both the worker and the service user in the shared space. The phrase “head, heart and hands signifies this holistic approach” (Ghate and McDermid, 2016, p. 6) and “all three being essential for the work” (Petrie et al., 2009, p. 4). It is not unusual for practice to be defined by a trinity of terms or through the use of a metaphor (Brühlmeier, 2010; Cameron and

Moss, 2011; Digney and Smart, 2014). The Therapeutic Daily Life Events⁴⁹ (Garfat and Fulcher, 2012; Digney and Smart, 2014) present embodied ‘relational child and youth care’ through a triptych framework of ‘thinking, being, and doing’. Johann Pestalozzi’s (1746 – 1827) trinity of ‘head, heart and hands’ is used as a metaphor for holistic practice in different educational contexts (Gazibara, 2013; Brown, 2014) with the most relative being social pedagogy (Ghate and McDermid, 2016). These terms are adopted here to represent how social care workers engage with others holistically, through the relationship using their head, heart and hands.

3.2.3.1 Thinking with the Head

Being cognitively engaged in practice involves using the head and your common sense in decision making and engaging with people (Smith, 2009). Thinking also relates to the workers’ attitude towards others, encouraging the worker to see the positives, the strength and resilience in others. Developing a relationship requires the personal skills of engaging, remembering details about the person, actively listening without interrupting them, and remembering the things they love and little personal things about them (McHugh and Meenan, 2013). Listening in for the rhythm of each service user and tuning-in to where they are in their life, is also important (Maier, 1992; Digney and Smart, 2014). Being cognitively engaged also includes concentrating on the person and ensuring that your thoughts remain present and focused on meeting their needs (Garfat and Fulcher, 2012; Fewster, 2013). The thinking stage of the daily life events includes an awareness of the developmental stages of the service user,

⁴⁹ Originally presented as the ‘25 characteristics of a relational child and youth care approach’ (Garfat and Fulcher, 2012).

rather than just focusing on the behaviour and the way they are acting (Fulcher and Ainsworth, 2012).

Social care work is requiring more cognitive engagement in the “technologies of care” (Smith, 2009, p. 9), the in-direct practices (Fulcher and Ainsworth, 2012) which includes all the paperwork, risk assessments, behaviour plans and reports that are required from a managerialism technical/rational approach to care. Foucault viewed paperwork as part of the mechanisms of power and control over the workers (Lea, 2017). The reports record how the service is provided, how workers meet the defined outcomes, and which outcome are valued and by whom. In questioning which outcomes are valued, social care workers will see the power relations at play, why some practices are enabled and others constrained. These records, completed by workers and managers, through their adoption of self-surveillance as a norm, serve to record the actions and observations of others (Lea, 2017). For example, an increased level of report writing is viewed as the main culprit for taking SCWs away from spending time with service users in children’s residential care, and this may be an issue faced by workers in different contexts (Mooney, 2014). The thinking stage also involves a reflection on the self in practice, which enables the worker to learn more about the role they play in all interactions and engagements with others, and also how to deal with the emotional side of the work.

3.2.3.2 Being with the Heart

When we have a relationship with another person, we share a part of ourselves, and we also put at risk our emotional self (Clarke, 2003; Lyons, 2013). Potentially, there

is pain in relationships, especially when the worker has become emotionally involved in trying to create an experience that is genuine, warm and real (McMahon, 2010). Workers are challenged in their training and practice to adopt the values and beliefs of unconditional positive regard and empathy (Lalor and Share, 2013) for the service users (Payne, Adams, and Dominelle, 2009). Social pedagogy describes this through the use of the German term '*Haltung*' "broadly understood as a personal and professional, ethical stance or attitude" [original emphasis] (Chavaudra et al., 2014, p. 58). Social care workers are attracted to the profession because they have a genuine interest in helping and supporting people, discussed later in section 3.3.1. But helping and supporting people can be emotionally difficult and challenging for the worker.

Being in a relationship with service user can be a difficult task, especially as workers "are called to negotiate a range of moral dilemmas to which there are not clear cut answers" (Smith, 2009, p. 9). This constant uncertainty is experienced as 'stumbling through' (Hingley-Jones and Ruch, 2016), especially if the person does not trust or know the staff member, or is dealing with their own issues. Ormond (2014) argues that even though the work can be very difficult and sometimes threatening, it is very important to relate to others in a non-blaming way, and 'survive' the work without becoming vindictive. He advises workers to be slow to judge, quick to use humour, and to become less self-conscious (Ormond, 2014). Within the relationship, workers struggle with knowing how much of the personal self to share with the people in their care. Danish social pedagogues use the term '*rummelighed*,' meaning "space or capacity" (Cameron and Moss, 2011, p. 79) to define the worker's "capacity to involve the self in the other's life" (Petrie et al., 2006, p. 24), and to demonstrate empathy in an appropriate way (Cameron and Moss, 2011). The social pedagogical

approach suggests the worker has three identities: private, personal and professional (Cameron and Moss 2011, p. 136), the ‘inner team’ of the 3Ps. The ‘personal’ identity shares hobbies and interests, likes and dislikes with the service users, while keeping the private ‘home’ identity, away from work. Students going on placement in Ireland are recommended to avoid ‘befriending clients’ as a way of learning to incorporate a boundary between personal and professional (Doyle and Lalor, 2013, p. 157). For Payne et al., to embody with the heart, is to take on the emotional role of the social care worker, and in doing so “they represent [that is, present to the people] their own personality and person, which they will use in interpersonal interactions with clients” (2009, p. 1). When a social care worker meets a service user or other professional, “it is the embodiment of social [care] work in front of them that they judge” (Payne, Adams, and Dominelle, 2009, p. 1), which includes their body and their hands-on approach to care.

3.2.3.3 ‘Doing with’ the Body: Being Physical and Using Touch

Social care is viewed as a ‘hands on’ role, where workers ‘do’ with others, though being together (Digney and Smart, 2014). These strategies include day-to-day tasks, ‘direct care tasks’ (Fulcher and Ainsworth, 2012) rituals of everyday life (Smith, Fulcher and Doran, 2013), and all the activities we do with people. The doing stage reflects how care is viewed as a verb, an action word, doing with others. The body engages in caring for the physical and intimate needs of others (Carnaby and Cambridge, 2005), and manual handling tasks, which may include; lifting, using hoists, pushing wheelchairs, and moving furniture and aids. As well as being trained to perform these physical tasks, the worker needs a level of physical fitness and

flexibility to accomplish these roles safely (Carnaby and Cambridge, 2006). Many students find providing for the physical and intimate care needs of service users difficult, and this is viewed as one of the main deterrents away from a career in the disability sector. Personal care tasks include shaving, skin care or applying external medication, hair care, help with feeding, teeth care, undressing and dressing, applying makeup and deodorant, and prompting to go to the toilet or bathroom (Twigg, 2000).

Intimate care duties, by virtue of the title, are more personal and include; dressing and undressing (underwear), helping someone use the toilet, changing soiled continence pads, bathing and showering, washing intimate body parts, menstrual care, administering enemas, and administering rectal medication (Carnaby and Cambridge, 2006). Advancement in assistive technology has significantly improved conditions for people with a physical and/or intellectual disability. SUs can use personalised programmes to ask for support or communicate their own choice to the worker (Ravneberg and Söderström, 2017). Providing personal and intimate care relies on a trusting relationship that facilitates touch in a safe, caring and dignified way (Twigg, 2000; Carnaby and Cambridge, 2005; 2006). While providing intimate care, the toilet, a traditionally personal space becomes a public work area, where it becomes difficult to ensure that a person's dignity will be maintained (Twigg, 2000). Twigg (2000, p. 145) also notes that bodywork, and dealing with human waste, the dirty work, is often left to the lowest paid or 'most junior staff', dismissed as less professional work. The following example in Figure 3.3 happened many years ago, but it stayed with me as a

reminder of how through routine or thoughtlessness, people can forget the importance of being respectful to others.

Several years ago, I visited a student on placement in an old hospital. The student was working in a large residential unit for ladies with a mild intellectual disability. Before the meeting began, the supervisor led me on a tour of the building. While walking along a wide corridor, the supervisor opened a toilet door as part of the tour, only to discover a service user sitting on the toilet. The supervisor did not acknowledge, or apologise to the person on the toilet, but continued to talk about the building, with the door open and the person on the toilet left exposed to all.

Figure 3.3 Dignity within Care

Touch can be a challenging practice for social care workers in different settings (Byrne, 2016). Smith (2009) spoke of the disturbing practice within children's residential care where workers are not allowed to touch the young people, to offer them comfort or a hug. Byrne (2016) spoke of defensive practices, where staff had to sit with a pillow between themselves and the young person on the sofa, to 'safely' sit beside each other. According to the Child and Family Agency (Tusla), registered child services need to establish clear procedures on a code of behaviour for workers (Tusla Children First Team, 2015). Policies can include guidelines for disclosing personal information and must include directions for staff on appropriate touch, which in some cases is a 'no touch' policy. These policies can contradict a person's natural inclination to hug a child that is hurt, "as one of the most obvious and most powerful ways to express care is through physical touch" (Smith, Fulcher and Doran, 2013, p. 44).

3.2.3.4 Doing can Hurt

“Workplace violence and aggression occurs when persons are verbally abused, threatened or assaulted in circumstances related to their work” (Health Service Authority, 2014). Violence and aggression in social care contexts are viewed as more damaging, based on the relationship between the service user and staff member, and the shared-living of social care (Keogh and Byrne, 2016). Table 3.3, on the following page, illustrates the responses of 17 placement supervisors⁵⁰ to the Newstalk Documentary ‘Who Cares for the Carers’ (Heron, 23rd of October 2015).

Rise in Violence	Culture of Acceptance
Total wreck due to constantly being verbally assaulted and also being aware that a physical assault can happen at any stage (S)	“no one will listen, I feel like it is my fault if I get hit” (S). “Safety measures do not go far enough to protect staff...they don’t protect anyone from that level of aggression and violence” (Newstalk)
I go into work anxious of what could happen through the day (S)	Don’t feel supported by the manager, don’t want to talk about how I feel (S)
Challenging behaviour can leave you feeling like a failure (PhD)	It is just part of the job now. I don’t feel supported and I am looking for something else (S)
Pushed, thumped, kicked, threatened, feeling threatened, sexually abused (Newstalk)	If the views of those working on the floor where more valued and accepted I feel this would help (S)
I have been beaten up, get spit at regularly, I am really hurt over and over again and nothing changes (S)	“ I knew it was part of the job and you know you are going to get decked” (Newstalk)

Table 3.3 Worker’s Response to Newstalk Documentary

The comments in Table 3.3 reflect a growing culture in social care that presents violence as a normal condition of work, and when present, workers are less reluctant to ask for help or even report the abuse. The culture within an organisation develops from the top down, and the manager’s response to incidents of violence in the

⁵⁰As placement coordinator I asked 3rd year social care students to talk to their placement supervisor about the Newstalk Documentary ‘Who cares for the carer? A survey monkey qualitative questionnaire was established to collect the voluntary feedback from placement supervisors. 17 supervisors commented on the documentary from November 2015 – January 2016.

workplace sets the conditions for acceptance, tolerance, support and supervision. “The manager came into the office and told the team -If she can’t take a few slaps, she shouldn’t be in the job” (Supervisor 14). These findings were mirrored in the 2016 report based on the experiences of 402 social care workers (Keogh and Byrne, 2016). Violence in the workplace was reported over three trajectories; the factors influencing violence, the impact of violence, and how it is managed (Keogh and Byrne, 2016).

Younger and less experienced staff were also addressed in the study, as they are more likely to be employed in high-risk settings and thus more vulnerable to assault (Cantwell and Power, 2016; Keogh and Byrne, 2016). Also, agency staff reported they had no access to injury benefit, with one worker commenting on how they received no compensation for the injury they sustained in work, leaving them both financially and physically hurt from the experience, especially if “there is a lack of organisational support available to them” (Keogh and Byrne, 2016, p. 55). The recommendations called for action against the policy of zero hour contracts and towards a recognition of the existence of violence in all sectors, and a change in the culture, where workers will not feel blamed for the violence they receive in their workplace (Keogh and Byrne, 2016).

3.2.4 Going Forward – Defining Social Care Practice

Regimes of competence may provide a relevant frame to establish the domains of knowledge within each setting, and examine the extent to which practice is a situated, indigenous and shared. The social pedagogical approach is most aligned with the rights-based approach that CORU (2017b) have defined within the standards of

proficiency for social care. It is also an approach that puts the relationship at the centre of its practice, “adopting a social pedagogical approach requires that Children’s services relinquish preoccupations with risk and protection to foreground ideas of growth through relationships” (Smith, 2009, p.156). Working in a relationship-based way has become a challenge for social care workers (Hingley-Jones and Ruch, 2016). This is not in reference to the circumstances where workers are engaged in a time-limited service, or are working with service users who have communication or intellectual difficulties inhibiting relationship development. Relationships between social care workers and service users are impeded by austerity measures imposed on services from neoliberalism and new managerialism. The temporary nature of agency contacts has forced both workers and service users to engage in the ‘dance of the unknowns’, without the essential component of the relationship (Garfat, 2004; Mulkeen, 2016; Cantwell and Power 2016).

“If the creation of a meaningful professional relationship is as important as the provision of material resources, then it could be argued that, on the grounds of effective practice and economic expediency, relational resources need mobilising as a matter of urgency” (Ruch, 2010, p. 18).

In conclusion, there is a valid concern that without a theoretical framework for social care practice, and a clearly defined purpose for the relationship-based, situated, holistic and embodied work, then social care will become devalued into social care assistant roles (with a social care work title) but without a valued opinion within the multi-disciplinary led services. The trinity framework of head, heart and hands, the social pedagogical and child and youth care lens, may support an exploration of the role of the relationship in practice, and how social care practice is embodied within the different settings, which may also include liminal situations. The chapter continues with the second theme in understanding social care; the workers’ identity.

3.3 Understanding Social Care Worker Identity

Understanding the twenty-six workers' (19 women and 7 men) experience of practice includes knowing how they see themselves, and how they perceive and express their identity in the role they play within a specific context of care. In this section, identity is understood through a sociocultural lens; which looks at what factors affect the identity, and secondly, in what way (Park, 2015). The social care workers' identity "is the stories they tell" about practice (Sfard and Prusak, 2005, p. 14), based on their situated learning (Lave and Wenger, 1991). Identity is not only experienced through title and story but also by the claims made about the worker, by themselves or others (Schachter, 2015). The social care identity is also formed through the performance of the negotiated practices and indigenous enterprises within the setting. Understanding workers in this chapter begins with how they are identified by self and others, through the claims made.

3.3.1 Self-identification as Caring, and Motivation to Care

Anytime we think about a person, we *identify* them (Evans, 2001), and this process is called *identification* (Jenkins, 2014), which is never complete, and always emerging and becoming (Hall, 1996). Within social learning theory, being recognised or feeling aligned to an idea or group is identification (Hall, 1996). Identification also relates to the description of an identity by self (Gowland and Thompson, 2013), referred to as self-identification (Bogo, Raphael and Roberts, 1993; Evans, 2001; Grøn, 2004). There is power in the first-person statements we make about ourselves (Shoemaker, 2001), I am a caring person, I like to help people, I am a social care worker. "I thoughts depend upon the knowledge we have in memory of our past states" (Evans, 2001, p.

97), and the ‘past states’ influencing people to become a social care worker has interested me throughout my academic career (Lyons, 2007; Lyons, 2013; Howard and Lyons, 2014). However, identification is not something we *have*, it is something we *do*, and just because we can self-identify as caring and wanting to help does not mean we will *do* social care (Jenkins, 2014, p. 6). Identification does not govern what people chose to do (Martin, 1995), “but without such a map we would not know where we are or what we are” (Jenkins, 2014, p. 6).

Waterman (2011) proposed that people make career choices based on the construct of *daimon*, or a sense of a true self. This is not a psychological view of identity based on attributes or traits; rather it relates to agency. According to Waterman (2011, p. 357), “living in truth to the *daimon*”, brings about feelings of happiness, through “personal expressiveness”. People are personally expressive when they recognise the potential of their personality towards a particular life choice. Lynch, Baker and Lyons (2009, p. 2) described how for some people caring is associated with a self-identified nurturing personality, where workers declare personal feelings of caring *about* the people they are paid to care *for*. Identification may not make us do something, but it is connected to motivation and can influence our choices (Jenkins, 2014), and for some people wanting to engage in social care work is deep-rooted, often declared as a need to help people from an early age (Byrne, 2009).

“I remember quite clearly when I first became involved in residential care. Initially, it involved a very powerful stirring of emotions – a surge of empathy and sensitivity towards the young people and their circumstances. My underlying motivation was a desire to help, to console, to make things better” (Ormond, 2014, p. 251).

Helping professionals can be unconsciously motivated to care for others (Eber and Kunz, 1984) because helping “becomes an integral part of one’s sense of purpose,

value and identity” (Lynch, 2009, p. 413). Many social care workers enter the profession because they have witnessed care of others (Paul, 2014). “My interest in care was ignited from witnessing a grandmother who acquired Alzheimer’s Disease” (Killeen, 2014, p. 95), and the kind way the staff treated her. Social care workers often have experiences that are similar to the people in their care, and this can also motivate them towards care work (Fabianowska and Hanlon, 2014). Canadian lecturer of Child and Youth Care Frances Ricks researched the life story of her students and discovered that “49% had three or more systems of dysfunction in their lives” in common with individuals receiving care (Ricks, 1993, p.23). According to Egan (2007, p. 25) people in helping professions may also be motivated to care because of the “shadow side” of helping, working in a helping profession to “help themselves heal”. Examples include meeting a need for power or love through the care relationship, or trying to cure yourself, or your past, through caring for others.

Being aware that past experiences can influence current practice, is essential for relational work with others (Bruce, 2013). The past is the lens through which we view the world, influencing how we experience the present (Lyons, 2013), and are with others. Krueger (1997) wrote about the importance of each worker acknowledging their life story in preparation for practice with others. His child and youth care students are encouraged to explore their life history, to create awareness of the potential for past experiences to colour what they see and do in the present (Krueger, 1997). Through self-study, social care students and workers can learn about why they were motivated to enter the profession in the first place and to use this knowledge to engage with others (Egan, 2007), in a positive way. The question of men being motivated to become social care workers is addressed in the following section.

3.3.2 Motivating Men?

The majority of the participants in this study are female, and the majority of social care workers are female which is reflected in the student population and the membership of SCI (see Table 4.1). Although there are only seven male participants in this study, I highlight the question of men in social care here to focus on what may motivate males to become social care workers, or keep them away. As well as a lack of prestige and low wages (Fisher and Tronto, 1990), Chapter Two has demonstrated how societal constructions of femininity have aligned the qualities of gentleness and the ability to care, to being female (O'Toole, 2009). Such constructions may alienate young males from entering the profession. In recent years, the profession has actively encouraged males to become social care workers by highlighting the job opportunities for men (Doyle, 2009; Lalor and Share, 2013). However, the suggestion to increase the prestige of the caring role by “just add men and stir” (Fisher and Tronto 1990, 35), does not address the gender inequality that exists in society and care based professions (Doyle, 2009).

Smith (2009) has written extensively on male social care workers, arguing that we need to review the literature that presents a binary view, with men being viewed as justice orientated and females more compassionate. O'Toole (2013) argues that further critical analysis on gender and power inequalities in social care is also needed, to emphasise that people engage in social care work with other people and it is the quality of their relationship, not their gender, that is central to this (Smith, 2009; O'Toole, 2013). The motivation to care is part of the worker's own journey and story, irrespective of gender, and their identity develops through “the stories they tell” about

practice (Sfard and Prusak 2005, p.14), based on their situated learning (Lave and Wenger, 1991).

3.3.3 Professional Identity Through Stories About Practice

Social care workers define their professional identity through discourses on the nurturing relationships they share with the people in their care (Lynch and Lyons, 2009). Identity or “*who-ness*, is something that can only be revealed through a story” about the practice you have experienced (Pithouse, Mitchell and Moletsane 2009, p. 158). Park (2015) states that experiences of practice and engaging with others is the first step towards understanding the development of a professional identity, because “identities *are* stories that people tell about themselves and others” (Vadehoncoeur, Vellos and Goessling, 2011, p. 227). Sfard and Prusak (2005) describe stories about practice as a “set of reifying, significant, endurable stories about a person” (Sfard and Prusak, 2005, p. 14). Reflecting on a story of practice enables workers to reassess their personal definition of being a professional worker, towards a more realistic and less judgmental view of their professionalism (Sfard and Prusak, 2005). Pithouse, Mitchell and Molstane (2009) wrote about the power of writing and telling stories to deconstruct and reconstruct new identities.

There is power in the story, and workers can reconstruct the identities of others within the stories they tell or write on practice (Pithouse et al., 2009). Social care workers have access to the life stories of others, recorded in case histories and stored in files. These files are part of the system that has formalised the social care workers’ way of engaging with others (Foucault, 1977/1995). The social care worker writes the

story of a person's life based on their interactions with them in the daily files and records, and there is power in this position. Also, workers' can re-write the story based on the relationship that develops, despite the 'evidence to the contrary' within their file. Reynolds (2014), demonstrates the power of writing people's stories down in a file.

“As a social care worker, hearing and reading information about a young person's profile can often be significantly at odds with my own conclusions following meetings and on building a relationship with that same person. The story or narrative that accompanies a young person, if it is allowed to, can often define or stereotype a person's character and personality” (Reynolds, 2014, p. 194).

Social care workers' stories about practice involve the relational work they do with others (Howard and Lyons, 2014), which is both a story about them and the other person. “A good story can be a powerful way of sharing practice” (Loughran, 2008, p. 219) and an essential tool for self-study (Pithouse, Mitchell and Moletsane, 2009). As well as identity being a story about practice, identity is also “a claim about who a person is” (Schachter, 2015, p. 230).

3.3.4 Professional Identity as a Claimed and Performed Role in Practice

Identity is a process (Lantolf and Thorne, 2006), which can be conceptualised as explicit or implicit claims about self (Schachter, 2015). Within this view of identity, if the claim is validated by self or other, the person is 'bringing off' an identity (Schachter, 2015). People have to adopt or 'take-on' a claim before there is any accountability. There are different standards to judge a claim, for example, if there is 'sameness and continuity' with comparable others (Erikson, 1968), or if the claim feels

‘real or authentic’ (Waterman, 2011) and “when they see themselves as professionals, they act professionally” (Gottlieb, 2013, p. 158).

Primarily workers use their relationships with others as a gauge of their ability as a worker and their identity. This includes one-to-one relationship feedback with service users, team meetings, peer feedback, and regular supervision. People judge themselves based on how they feel others are judging them, especially if the ‘others’ are of value (Erikson, 1968), so if valued, the views of a service user, colleague or supervisor can influence the identity claims of the worker. Identity needs external validation from this ‘valued other’ to affirm the claim (Blumer, 1969). Share (2009) argued that professional identity is linked to how the other ‘professionals’ within that context view the professionalism of social care, or not (Schachter, 2015). In many sectors, social care workers are part of a multi-disciplinary team including social workers and nurses. If the social care worker does not feel recognised as a professional within the team, they may adopt another professional role or identity, or complete alternative ‘professional’ training (Wilkinson, Hislop and Coupland, 2016). Thus, the other disciplines within the setting can greatly influence the worker’s identity claim.

Identity claims can occur in three different trajectories (Wenger, 1998), which are not mutually exclusive, “within a person, or between a person and others”, or “between others external to the self” (Schachter, 2015, p. 231), and all are influenced by mechanisms of power (Foucault, 1977/1995). People evaluate and judge identity claims on an ongoing basis, using the power relations they engage in as a guide for future actions. As the social care worker engages in the negotiated practices of social care, an identity solidifies (Schachter, 2015). Identity claims are also context specific,

and relationship specific, so they may not be relevant to another person or setting. A competent social care worker with experience in a disability setting may feel unable to bring off a professional identity claim in another setting, for example, residential care for children. If the worker feels they can perform to the expected norms, or indigenous enterprises in the 'regime of competence' (Wenger, 1998), their identity is affirmed. Identity is also described as performative, and when there is a sustained performance, the identity is owned and claimed.

3.3.4.1 Identity as Performance

Viewing identity as socially constructed is a core premise of sociocultural theory, through engaging with other, the self is constituted, and "the very practice of self-constitution is performed" (Butler, 2005, p. 114). Although talking specifically about gender, Butler (1990, p. 180) stated that the "attributes effectively constitute the identity they are said to express or reveal". Thus identity is performative and according to Butler (1990, 2004) this implies that identity is not given, it "is manufactured through a sustained set of acts". Applying this theory to social care, workers' identity is formed through the performance of socially intelligible and acceptable acts of social care. When the social care student/graduate is in the workplace the reality of a 'social care worker identity' is created through "a performance that is repeated" (Butler, 1990, p. 191), the worker will 'fake it until they make it', through performance, until it becomes a reality. When a social care worker is describing who they are to others using their claimed or performed identity, that discourse is controlled by the social relations and power relationships of that context (Foucault, 1977/1995; Badenhorst, 2015). They are performing to that specific audience, and only the aspects of self they

feel will be accepted, are shown (Sommerfeldt, Caine and Molzahn, 2014). The worker is not necessarily free to act as they choose, as identity performance is embedded in subtle mechanisms of power that constitutes social care practice (Foucault, 1977/1995).

In social care contexts influenced by new managerialism, focusing on performing the tasks of social care places an emphasis on an external performance, wanting to be seen ‘doing’ social care (Harrison and Ruch, 2007), thus ignoring the ‘being’ and ‘cognitive’ aspects of the practice identity, essential for relationship based practice (Garfat and Fulcher, 2011; Fulcher and Ainesworth, 2012). The fear is that workers will only value the ‘doing’ tasks of social care, what can be measured as a product of their work with others. The chapter continues with the ongoing identity of the worker as a situated learner.

3.3.5 The Worker as a Situated Learner

Vygotsky believed that learning is a human activity which “takes place in a cultural setting and cannot be understood apart from these settings” (Woolfolk, Hughes, and Walkup, 2008, p. 52). Situated learning is a distinct theory and not to be confused with ideas about ‘learning by doing’ or ‘learning in situ’, it involves the whole person, where “agent, activity and world mutually constitute each other” (Lave and Wenger, 1991, p. 33). Social care workers and managers rarely talk about social care practice as a learning experience or identity as a learner in practice (Howard and Lyons, 2014). “One reason they do not think of their job as learning is that what they learn is their practice” (Wenger, 1998, p. 95). Learning is presented here as an acknowledgement

that people learn from actively engaging with others, their ‘more skilled partners’, which includes their colleagues, other professionals, and service users in a specific care context (Rogoff, Matusov and White, 1996; Rogoff, Turkanis and Bartlett, 2001).

This idea of learning partnerships is based on a ‘communities of learner’s model’, presented by Barbara Rogoff and her colleagues, and inspired by John Dewey and Lev Vygotsky (Rogoff et al., 1996, 2001). Here, social care workers participate ‘collectively’ with colleagues, as both expert and novice, thus engaging “in learning activities in a collective way” (Rogoff et al., 2001, p. 7). Social care workers learn to perform the skills of practice, and over time they learn to read situations and people, until they cognitively, emotionally and physically ‘know how to act’ (Butler, 2005). Learning is more than the internalisation of knowledge through the process of transmission and assimilation but is based on the transformation of ideas through the interactions between the old-timers and newcomers (Lave and Wenger, 1991). Workers need to feel that they are transforming practice through engaging, sharing, negotiating as part of the practice team, and in doing so, transforming themselves. Workers also learn about practice from being a supervisor to the newcomers and students on placement.

Social care students in Ireland learn about practice through the placement, a block of time they spend within a social care setting⁵¹. In an ideal placement, students are exposed to practice reifications in the guise of in-house policies and forms, and experience the negotiated process of meaning making as workers communicate and engage in the daily activities (Lancaster, 2014). The learning happens through the

⁵¹ For example, in ITB, students complete twenty-six weeks of placement over two years (13 weeks, 35 hours per week in both years two and three).

student's engagement with the setting and with the mentor (practice tutor) (Lancaster-Byrne, 2014) and continues after graduation in the day-to-day experiences of practice. In the setting, the student learns by performing the identity of a social care worker, through imitating the workers around her, until by sustained activity the identity is manufactured (Butler, 1990, 2004, 2005). Students also learn how to form relationships through observing and modelling the behaviour of the practice teacher (Graham and McGarry, 2002). In reality, the situated learning on placement is inconsistent and dependent on many variables, including, the skills of the practice teacher, the quality and suitability of the placement, the culture and the current climate of the setting, to name a few (Doyle and Lalor, 2013).

In conclusion, social care workers are motivated to help, because helping aligns them to their 'daimon' (Waterman, 2011) and sense of purpose, their desire to fulfil own needs, or because they had an early experience of care. Motivation to become a social care worker is related to the workers' identification as a helper, but internalising the identity as a social care worker relates to the identity claims made, and how these claims are valued and acknowledged by others. Social care workers perform the indigenous practices of social care until they are learned and internalised. Workers are continually engaged in situated learning of the changing practices and roles, and also share their knowledge with others, especially students on placement. This chapter continues with the final theme of social care work, the contexts of care.

3.4 Social Care is Context

During social encounters, when a worker is asked ‘So, what do you do?’, the answer inevitably locates their work within a specific setting of practice, for example, ‘I work in a treatment centre for people with addiction’, or ‘I work with children in a residential centre’. In answering the question, the social care worker is presenting their practice and identity (McSweeney, 2011), as situated in one setting. A distinct feature of social care work is that the majority of workers are located within a fixed context, a specific service. The service users may come and go, but the worker is situated in this space. In this section, the contexts of care are described as encompassing the service’s history, material culture, architecture and the people who work and live there (Woodward, 2007; Hicks and Beaudry, 2010). Practice settings are also the places and spaces that workers and SUs inhabit which are flexible and adapted to meet diverse needs and practices. Specific spaces are also purposefully used for relationship based work, which includes the car, the kitchen and outdoor spaces in the community. As well as being a practical base for the provision of care, contexts also evoke feelings, of being welcome, or feeling at home. Finally, this section addresses the situated learning that is contained within the context.

3.4.1 Understanding Contexts

The term ‘context’ has appeared within sociological, anthropological and geographical debates relating to agency, structure, locality and space (Duff, 2007). However, the meaning of context is ‘still uncertain’ (Duff, 2007, p.504). Defining the term as a ‘complex concept’, McCormack et al. (2002, p.94) state that “context specifically means the setting in which practice takes place”. Context is also used to define a

“place, period, or linguistic community” (Barnett, 1999, p. 280). For sociocultural theorists, it is the ‘social context’ which defines the shared social world (Lantolf and Thorne, 2006), including the “tools and cultural objects, as well as people” (Kozulin, Gindis, Ageyev and Miller, 2003, p. 160). Context is also defined as the background for all social interactions which are influenced by cultural, historical, political and economic constructs (Burr, 2015). However, context is more than a backdrop; context is a social, active and emergent space (Wenger, 2010). The tools and cultural objects including “ideas, representations and theories” are “intrinsically connected to the particular contexts in which they are produced” (Barnett, 1999, p. 279). Therefore, context is practice (Barnett, 1999) people, and structures.

Contexts are shot through with power relations, for example, the bureaucratic norms and discourses of new managerialism, and historical, religious and medical ideologies (Harvey, 2005; Lynch, 2012). Social care contexts are still emerging from a culture of religious management, vocational ideology, unskilled labour and unregulated practices. However, in the past ten years, there is a move towards secularised, centrally regulated standards of practice and service delivery, within the contexts of residential child care, services for people with physical and/or intellectual disability, homeless services, addiction, and child and adolescent mental health. These services are in a state of flux, changing to meet the diverse needs of service users, and the current economic climate of retrenchment, and the political and managerial climate of new managerialism. The context is the physical representation of how the practice is influenced by policy, and valued by society. Contexts are adaptive and can be day centres or residential homes, hostels or treatment services. The socially constructed

contexts of social care include places that are meaningful (Tuan, 2012) and spaces that are lived-in (Merleau-Ponty, 2012).

3.4.2 Social Care Settings -Space and Place

Social care workers inhabit the contexts of practice; they engage in the activities and movements of social care, through their holistic and embodied practice, from physically pushing a wheelchair or using a hoist, sitting beside someone in the shared space, to cognitively and emotionally ‘being present’ (Digney and Smart, 2014). The contexts of practice are diverse, and each worker is engaged in completely different activities depending on the needs of the service user in that place, space and time.

“Place is not only a fact to be explained in the broader frame of space, but it is also a reality to be clarified and understood from the perspectives of the people who have given it meaning” (Tuan, 2012, p. 387).

The discussion on contexts of care requires some understanding of the concepts of place and space (Lefebvre, 1991). As with the term ‘context’, definitions for space and place come under the auspices of geography, religion, sociology, culture, to name a few (Randviir, 2002; Hubbard and Kitchin, 2010; Milligan and Wiles, 2010). For geographer Doreen Massey space is a “complex web of relations of domination and subordination, solidarity and cooperation” (Massey, 1993, p. 81), while place is more local, concentrated and within spaces (McDowell, 1996; Massey, 2005). McDowell (1996, p. 29) articulated a relational definition of space, where “all social relationships occur somewhere and result in connections between people and places” Place is presented as the ‘nodes’ of space, a ‘symbol’ of space that is ascribed with “personality and spirit ... the sense of place” (Tuan, 2012, pp. 388 - 389). The personality of a place

is felt, remembered with affection or hate, and recollected from a smell (Tuan, 2012), taste, or a photograph.

Workers and service users shape the figured worlds of social care and are ultimately shaped by them. ‘Figured worlds’ is a concept coined by Dorothy Holland, William Lachicotte, Deborah Skinner and Carole Cain in 1998, to look at how people make sense of their world. A figured world is a “socially and culturally constructed realm of interpretation in which particular characters and actors are recognised, significance is assigned to certain acts, and particular outcomes are valued over others” (Holland et al., 1998, p. 64). Each social care setting is its own culturally figured world. Holland et al. (1998) assert there are four concepts of the figured world. Firstly, as quoted above, we enter a figured world, and it develops based on our participation within it. In the figured world, position and rank are important as a means of access. Thirdly, like activities, figured worlds are performed and constructed through the roles enacted by members, and finally, cultural worlds are populated by people who give it life (Holland et al., 1998). The question of ‘where social care work happens’ includes both an identification of relevant social care spaces, including the specific places where care is experienced and meaningful moments shared. Social care places are residential or daycare centres which become a home; a place for work and/or activity, treatment, care and love (Lalor and Share, 2013; Byrne, 2016).

The actual architecture, the environment itself is a monument to the residual ideologies, especially within services that evolved from religious or medical dogmas. Foucault was interested in how the architecture of prisons and other institutions were purposefully designed to enhance the mechanisms of discipline and surveillance, the ‘panopticon effect’, where surveillance is internalised, and everyone acts as if they are

under constant regulation (Foucault, 1977/1995). Social care services were originally housed within large institutions, with large open dormitories enabling the staff to observe and discipline large numbers of children (Department of Education, 1970; Raftery and O'Sullivan, 1999). Although care has moved from congregated settings to smaller community based units, the subject (the worker and the service user) is still ordered (Foucault, 1977/1995) through the residual ideologies within the walls, and through the political architecture of the space.

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

3.4.2.1 Ordinary Spaces: The Car, Kitchen and Outside in the Community

Social care workers purposefully use the ordinary places within and external to the service to perform social care work. The following places are used for purposeful social care work; the car, the kitchen, and engaging in community spaces. Justifications for the use of these specific places are presented below.

The Car: The role of the car as a practice space within the helping professions, has attracted scholarly consideration (Ferguson, 2009, 2010; Ross, Renold, Holland and Hillman, 2009). The symbol ‘car’ is presented as not fixed or static, but as meaning different things to people and cultures (Milar, 2001; Bull, 2004). The car can be an expression of care and humanity, through the act of collecting and bringing someone where they need to go (Miller, 2001). It can also be a symbol of freedom, a private space with the music so loud that the external noises and the world outside the car is shut out (Bull, 2004). The car has become so necessary for social care work that many organisations list having a full driving licence as a prerequisite for employment (Ferguson, 2009). As well as being used to bring people to their destination, for example, to school, or on an access visit, the car is also a space for purposeful relationship based work. Relationship based social care work happens in the car, not by accident, but as “a product of the design of cars” (Ferguson, 2009, p. 276).

There are three factors which facilitate the role of the car for purposeful social care work, which firstly is the reason for the journey (Ferguson, 2009). Secondly, being in the confined space of the car and moving between fixed spaces creates a pause in ordinary life, and finally, the arrangements of the car seats creates a physical space between the passengers, including the avoidance of direct eye-contact (Ferguson, 2010). Ross et al. (2009) spoke of how relationship based social care work can become

framed and bounded within the car. Sitting within the physical boundary of the car made the young people feel safe, and this feeling encouraged them to share and have intimate ‘car conversations’ (Ferguson, 2009). Rose et al. (2009, p. 612), described these ‘car conversations’ as free flowing, “offering a means through which young people could share past memories, associations, and future imaginings that the journey brought to mind”. Figure 3.4 depicts a drawing of people engaged in a ‘car conversation’. The worker is looking forward, and the lack of eye contact enables the young person to chat freely, without feeling they are under surveillance (Foucault, 1977/1995).



Figure 3.4 Car Conversations

The Kitchen: This room plays a central role in ordinary family life (Sarkissian, Hofer, Shore, Vajda and Wilkinson, 2009) but also in the lives of service users and social care workers (Byrne, 2014; 2016a.). As well as the place designated for eating, the kitchen is also the room where people gather to perform activities, for example, young children doing their homework (Sarkissian et al., 2009). In the home, families eat around the kitchen table, and this practice is viewed as part of normalisation in residential life (Byrne, 2016a). The kitchen table is also a place for communication and relationship development, where the table provides a focal point for a relaxed and non-threatening discussion (Coote, 2014). The poet Joy Harjo described the multiple life experiences that have been centred around the kitchen table in her poem ‘Perhaps the World Ends Here’ (Harjo, 1994, 68). The poem describes the kitchen table as a monument for all life, “the world begins here, we eat to live”, and describes how the table was used by families throughout history, for giving birth on, as the resting place in death, for shelter, and family gatherings. She continues with an array of daily experiences that are centred around the table; gifts are wrapped there, people are gendered and socialised there, a place for gossip over tea (Byrne, 2014; 2016a), and to tell the stories of your day (Harjo, 1994).

The kitchen is also a space where gender roles are practised, learned and adopted by the family. People have their own seats at the table, and position at the table evokes status, which can reflect the gender of family members (Anzaldúa and Keating, 2002). Byrne (2016) argues that the kitchen is an illustration of the mechanisms of power in practice, from the resistance to food and dining habits that plays out in that space. As noted in Chapter two, Irish Catholic familialism and patriarchal traditions led to the subservience of women towards the males in the family

in Ireland (Magray, 1998; Blasi, Turcotte and Duhaime, 2002; Gilligan, 2009), women served, and men sat at the kitchen table (Wilmer and Dillon, 2005). Cooking and preparing meals is still considered women's work (Stapleton and Keenan, 2009). As a predominantly female profession, the kitchen is now the space where female social care workers can challenge their own perceptions of gender roles (Smith 2009; Smith et al., 2013).

Although the kitchen is a dominant space within all services, including day and residential, there is limited research on the role of the kitchen and the potential use of the space for social care work, beyond residential care. Byrne (2016a) looked at the role of food in children's residential services, and the kitchen table was a feature in her research. In children's residential care eating at the kitchen table is a melting pot of normalised practice, which includes activities which demonstrate care, or alternatively exercise discipline and control of both the staff and the young people (Foucault, 1977/1995; Byrne, 2016a). Mealtimes and the formal rules of eating at a table are often viewed as stressors for service users (Trieschman and Whittaker, 1969). Eating at the kitchen table in services for people with physical and/intellectual disabilities can be a multitude of different events, from the traditional gathering of staff and service users to people being fed wherever they are seated (Adolfsson, Sydner and Fjellström, 2010).

The Community: Getting out and doing shared activities together outside is an important part of the shared experiences of social care work (Fulcher and Ainesworth, 2012; Smith, Fulcher and Doran, 2013). Eating out in the community is an important social activity for people with an intellectual disability (Adolfsson, Sydner and Fjellström, 2010). However, this activity may be limited based on multiple possible

factors; the unsuitability of the space for people with a disability, any behaviours that challenge from the service users; specific food allergies or requiring food liquidised or thickened (Adolfsson, Sydner and Fjellström, 2010). Rose et al. (2009) also spoke of the role of walking as an important activity for community engagement and social learning. Walking in the local neighbourhood is part of travel training for people with a disability, and is viewed as one of the ways to achieve community engagement in the *New Directions* report (Health Service Executive, 2012b). Getting out in the community emerged within the ethos of the normalisation of public and private spaces for the care of people, from the institution to the home (Gilbert, 2009). In section 2.4.3 Gilbert (2009) traced welfare ideologies as passing through the age of the workhouse (1850-1910), and the colony (1910-1970), to the period of normalisation (1970-1995). This stage was defined by the discontinuation of large congregated settings in favour of smaller community based homes, with an increased focus on getting out into the community (Gilbert, 2009; Health Service Executive, 2012b). Within the current regime, Gilbert (2009) argues the possibilities of providing choice and increased access to the community are reduced, due to limited funding and reduced staff level. The chapter continues with the construction and representation of the context as a home.

3.4.3 Creating a Home

“Home! And this is my room, and you're all here. And I'm not gonna leave here ever, ever again, because I love you all, and - oh, Auntie Em - there's no place like home” (Quote from Dorothy - Wizard of Oz, 1939).

Social care workers are sometimes employed in a space that is defined by the service user as their home. What does a home feel, or look like? Ferrari, Jason, Sasser, Davis,

and Olson (2006), assert that people experience home both physically and psychologically. The psychological ‘sense of home’ is experienced as a safe space to be yourself and express your personal identity “we can relax when we come back to it, put our feet up, be ourselves” (Cooper, 1974, p. 131).

“Most people who live in a care home want the full package, the home as well as the care. They want a physical environment that expresses love, care and respect, a room to call their own, and a building and garden; that feels comfortable, homely and safe” (Burton, 2015, p. 143).

There is a tension for social care workers to make care contexts less institutional (Byrne, 2016) and more “safe, comfortable and homely” (HIQA, 2013, p. 29). However, philosopher Jacques Derrida argued against trying “to naturalise, what is not natural, and not to assume what is conditioned by history, society or institutions is natural” (Dick and Kofman, 2002). Trying to recreate the experience of home within an unnatural setting is a difficult task, especially as there is limited scope within practice to discuss the meaning of home for both workers and service users. The idea of creating a homely space for people to live has become a national standard in all government publications on residential care since 2004, who stipulate; “it should be as much like an ordinary family home as possible” (Department of Health and Children, 2004, p. 31). Cooper (1974, p. 131) described ‘home’ as a personal space where we have control over the “few intimates that we invite into this, our house”, especially the people we live with. In reality, service users have limited control over the people invited to live, to visit, or work, in the space (Health Service Executive, 2011). The appropriate placement of residents together in the one house is paramount, as it can be very destructive to a resident’s placement if they do not get along with the other residents (Reynolds, 2014). Having your own bedroom within the house can also increase the sense of home (Ferrari et al., 2006).

The physical house is also viewed as an expression of self, “we project something of ourselves onto its physical fabric” (Cooper, 1974, p. 131). The expression of self is manifest in the material culture of the space including furniture, the way it is placed around the room, the selection of photographs and images hung on the walls (Woodward, 2007; Hicks and Beaudry, 2010). Within residential services, SUs may have limited involvement in the purchasing and placement of furniture and personal items within the house other than their own bedroom.

The desire to create a homely atmosphere is aided through rituals and social practices, for example making a cup of tea for people when they arrive at a day service or sharing a cup of coffee and a chat during the day in a residential house ((Reynolds and Herman-Kinney, 2003; Gallagher and Edmondson, 2015). Byrne (2016) discussed how staff used the cup-of-tea both as a way of engaging with the service users, but also as a way of alleviating stress within the day, to take a break and have a cup of tea. This is most common for residential care staff who are not permitted to take a break away from the unit. Making tea is also a ritual between the staff members, where team meetings can evoke feelings of family and engagement, by starting with a cup of tea (Martin and Rogers, 2004). Staff members can also feel more at home if the management creates a culture and atmosphere of respect where individual opinions are heard (Martin and Rogers, 2004), in the negotiation of practice (Wenger, 2010).

The condition and maintenance of the building also affects the way we feel in the space when we live or work there. The way we emotionally connect to a place determines how we act in the space (Hutchison, 2004). In 1967, social scientist Albert Biderman wrote a report on how people reacted to the aesthetics of the environment in which they lived (Kelling and Coles, 1996). If the building felt like a space in which

they lived, rather than their home, they would care less about it. “If a window in a building is broken and left unrepaired, all the rest of the windows will soon be broken” (Wilson and Kelling, 1982, p. 31). The idea became generalised into the ‘broken windows theory’, which influenced policy makers in America to invest and improve deprived areas, to reduce crime (Kelling and Coles, 1996). Social care workers have a variety of roles to play within their duties and responsibilities, including the maintenance and care of the service, including repairing the broken windows. One of these duties includes the care and cleaning of the context of practice. According to one employer, the responsibilities of social care workers includes their ability to “take part in the tasks which make the house a home, routinely cooking, cleaning (the house, grounds, vehicles, etc.) and carrying out basic repairs” (Positive Care Ireland, 2016). The level of cleaning expected within a centre can vary, based on the purpose of the unit, the needs of the service users and the expectations of staff and management. Social care workers are open to criticism from other staff and management about their attitude towards cleaning, and their ability to clean (Lyons, 2013). Cleaning is often viewed as an auxiliary task that takes the worker away from their main role, spending time with the people in their care (Mooney, 2014). With report writing described as the main culprit, “add to this the day to day household chores and activities including driving, phone calls, trips to shops” (Mooney, 2014, p. 149), there is no time left to be with others.

To surmise, in social care contexts, the workers engage with others in a relational space (Krueger, 2004), physical space, a landscape of care (Milligan and Wiles, 2010). Social care spaces are never fixed or absolute, but emergent and adaptive to the needs of others, while remaining relative to the internal and external structures.

Social care workers and SUs makes sense of the figured worlds of care through the material culture and personal items that make the service feel like home. Also, workers purposefully use spaces including the car, the coffee shop and the kitchen for meaning moments. Understanding the context of practice acknowledges space, setting, time but also the activity and embodiment of relational practice, and how the space is used by everyone.

3.5 Conclusion

To understand social care is to acknowledge that practice, identity and context shape and are shaped by the breadth, depth and complexity of practice. Social care practice is presented as relational, emotional, caring, physical, and sometimes experienced within liminal situations. Of the many theoretical frameworks to define social care work, this chapter considered the significance of situated learning through Wenger's (1998) regimes of competence and the social pedagogical/child and youth care approach to practice using a triptych frame. Taking a normative stance, defining the core elements of social care practice from workers within different settings can inform and/or contest how social care is defined by the regulating body. Identity is presented as situated, claimed and performed in a specific context, as the worker negotiates, participates and learns within the specific context. The contexts of care are situated, figured, embodied, and homely spaces and places. The discussion continues in the next chapter which introduces the research strategy used to collect the lived-experiences of practice from twenty-six social care workers in eight different settings.

Chapter Four Research Design

4.1 Introduction

“I want to understand the world from your point of view. I want to know what you know in the way you know it I want to understand the meaning of your experience, to walk in your shoes, to feel things as you feel them, to explain things as you explain them” (Spradley, 1979, p.34).

Social care workers learn their professional identity (Park, 2015), and the meanings and symbols of practice (Reynolds and Herman-Kinney, 2003) through engaging and negotiating with others (Wenger, 1998). The methodological approach to the question ‘How is social care practice experienced by workers in diverse settings in Ireland?’ is governed by a research design (Maxwell, 2013), involving a “specific topic, methodology, procedures, conduct and reporting” (Simons, 2009, p. 99). A holistic multiple case study approach (Yin, 2009; 2016) elicited the experiences of twenty-six social care workers in diverse practice spaces, viewed through the integrated theoretical lens of sociopolitical theory, sociocultural theory and social pedagogy. Purposive and snowball sampling aided the case selection of these workers within three case clusters for analysis. Case study research stresses the importance of a triangulation of data sources to provide rich data (Stake, 2006). Arts-based methodological tools including photographs (Rose, 2016), and stories (Sfard and Prusak, 2005) were used in conjunction with in-depth focused interviews, to draw out the experiences of workers within different social care spaces (Tellis, 1997; Simons, 2009). This thesis also introduces a process defined as *visual reading*, using drawing as a visual interpretation of the transcribed meanings provided by workers on their experience of practice.

This chapter begins with a discussion of the research philosophy and paradigm, constructivism, which underpins this study. A rationale is presented for the relevance of case study research to the constructivist paradigm. Based on a desire to provide a clear structure for the application of case study research, the framework proposed by Yin (2009) was utilised to expound the research question, which also forms the structure of the remainder of this chapter;

- Stage One: The Plan – In case study research the plan establishes the research question and presents a rationale for doing a case study.
- Stage Two: The Design –The second stage of case study research begins with an introduction to the selected units of analysis and ethical procedures.
- Stage Three: Prepare –This stage outlines the necessary steps required before conducting case study research; the pilot study and case study protocol.
- Stage Four: Collect – Introduces the multiple methods of data collection; focused interviews and the arts-based research method photo elicitation.
- Stage Five: Analyse – Braun and Clarke's, (2006) six phase guide to thematic analysis was used, complemented by visual reading and qualitative software NVivo.
- Stage Six: Share – The research is complete when the report linking the analysis of the data to the propositions, is presented and shared.

The research stages in general, and case study stages more specifically, are intertwined rather than occurring in sequential steps. As such, topics may be noted in some stages and then discussed in detail later in the chapter. This journey begins with the research aim and objectives.

4.1.1 Research Question and Aims

The aim of this research is to explicate the worker's voice on his or her experience of practice in diverse settings. Hence, this research set out to explore;

- What is the experience of social care practice for these workers?
- How is learning situated and shaped by the specific practice space, and what meanings and shared and indigenous enterprises are created within each setting (Lave and Wenger, 1991), and are some practice issues within the realm of liminal situations (Turner, 1969)?
- What is the significance of the social pedagogical trinity of head hands and heart (the child and youth care lens) to understanding social care practice and informing imminent regulation processes in Ireland?

In relation to worker identity, the following themes were explored;

- What is the SCW's personal journey into care and what motivated them to become a SCW?
- In what ways do SCW's identities develop, and how is this development influenced by their relationships within the setting?
- What kinds of identities are claimed and/or performed in practice?
- What is the impact of social care worker/non-social care worker title on professional identity?

To examine the influence of context on the social care workers' experience of practice, the following subquestions were also examined;

- What specific spaces do social care workers gain employment in, and how have these services evolved from residual ideologies of the deserving and undeserving poor?
- What individual differences are experienced within the similar settings or between different contexts? Are there unifying themes, enterprises and/or domains of knowledge, for social care work within these diverse settings?

4.2 Research Philosophy and Paradigm

Central to the development of a good research design is understanding your research philosophy, or paradigm (Maxwell, 2013). A paradigm is a worldview, a "philosophical framework that shapes the research" (Farquhar, 2012, p. 16), and a

‘theoretical perspective’, which informs the type of research performed and how data is collected and analysed (Crotty, 1998). However, as Bredo (2006) contends, deciding on your worldview depends primarily on your view of the concept of ‘knowing’: the epistemology or ‘nature of knowing’. As mathematics was favoured as a way of knowing in the natural sciences, initial research studies were primarily influenced by a philosophical empiricist view, and the work of early luminaries such as John Locke (1632 – 1704), George Berkeley (1685 – 1753) and David Hume (1711 – 1776) which became known as a positivist approach to research, further developed by Auguste Comte (1798 – 1857) in the 19th Century. For Comte, knowledge can only be acquired through measurable, observable and empirical scientific methods (Comte, 2000).

Positivists are concerned with what we can experience through our senses from the external environment, or the “interface between the mind and the world” (Godfrey-Smith, 1998, p. 32), ‘the outside-in view’. Positivism was the primary approach used in social science and educational research up to the 1960s (Bredo, 2006) before it was overcome by criticism, known as the paradigm wars (Gomm, 2009). The main postpositivist paradigms that emerged from the paradigmatic war included; constructivism (or what was to become known/referred to as interpretivism), transformativism, pragmatism (Mertens, 2010a; Monette, Sullivan, and De Jong, 2011), and the postmodern paradigms of; subjectivism, critical theory, structuralism and feminist theory (Crotty, 1998). Postpositivists are interested in “contributing to *meaning* rather than testing theory” [my emphasis] (Kasi, 2009, p. 96), and are primarily influenced by an internalist philosophy, ‘the inside-out view’ (Bredo, 2006).

Interpretivists argue that human behaviour (human science) does not fit within the positivist scientific approach, because “we explain nature but understand mental

life” (Rickman, 1976, p. 89). Understanding social care as the socially constructed concepts of worker, context and practice is leaning ontologically and epistemologically towards exploring meanings ‘from the inside out’. The characteristics of each postpositivist paradigm are distinguishable when defined by the following criteria; “axiology (nature of ethics), ontology (nature of reality), epistemology (nature of knowledge and the relationship between the knower and that which would be known), and methodology (the appropriate approach to systematic inquiry)” (Mertens, 2010b, p. 470). Methodology is the practice of inquiry which includes the specific methods of questioning, the sampling criteria, the research design, and the ethical guidelines used (Teddlie and Tashakkori, 2009). Although various internalist paradigms emerged as a reaction to the externalist positivist view, there are important philosophical and methodological differences between them. The theoretical approach most aligned to my epistemological, ontological and methodological worldview, is constructivism.

4.2.1 Constructivism

In the early 1990s, Egon Guba (1924 – 2008) and his wife Yvonne Lincoln, influenced by the philosophies of Immanuel Kant (1782 -1804) the ideas of Lev Vygotsky (1896 -1934) and Jean Piaget (1896 -1980) began to describe a paradigmatic approach called ‘naturalistic inquiry’, which became known as ‘constructivism’ (Guba and Lincoln, 1989; Lehman and Grabowski, 1995; Fosnot, 2005). Constructivism marked a shift in the epistemology of the nature of knowledge, with a recognition that truth is not absolute. The constructivist paradigm is also aligned to the constructionist epistemological stance (Crotty, 1998) in that, truth and reality are socially constructed

(Lehman and Grabowski, 1995). That is to say; this position is predicated on the view that social phenomena and their meanings are not only produced through social interactions but are in a constant state of revision by social actors themselves (Bryman, 2001). As Guba and Lincoln, (1989, p. 12) contend, realities are not objective ‘out there’, but are constructed by people” (Guba and Lincoln, 1989, p. 12). Facts are formed subjectively, and the interpretation of a phenomenon or case is context-specific, and therefore cannot be generalised to another setting (Guba and Lincoln, 2005; Stake, 2006). Social learning theory, sociocultural theory and social pedagogy are constructivist theories based on their belief that knowledge is socially constructed with multiple realities.

4.2.2 My Research Journey: Substantive and Methodological Orientations

Under the constructivist paradigm and strongly aligned to the historical lineage of internalism (people’s meanings are relevant) and structuralism (where nothing has a ‘given’ reality; Bredo, 2006, p. 9), qualitative research approaches emerged (Marshall and Rossman, 2006). According to Mertens (2010a), there are different types of qualitative research including but not limited to; ethnographic research (Spradley, 1979), case study research (Baxter and Jack, 2008), phenomenological research (Heidegger, 1953), grounded theory (Charmaz, 2006, 2008), and participatory action research (McIntyre, 2008). The choice of method, as well as being paradigmatically aligned, and suited to the research question, is also the result of my subjective decision-making process. Deciding on the best fit can be challenging for a researcher as many methods suit a qualitative approach to this thesis/specific research question (Crotty, 1998). Figure 4.1 uses a classroom scene of children putting their hands up

and asking the teacher to ‘pick me, pick me!’ as a metaphor to visually represent the difficult challenge in choosing the most suitable method for this research question.



Figure 4.1 ‘Pick Me -I am a Good Fit for You’ (Source: Pencil drawing by Denise Lyons)

My PhD journey was not a linear process, but a mystery tour through an array of methodological approaches to find the best fit between question and theory. In the beginning, my initial research proposal concerned the gap between training and service provision, asking if social care education was fit for purpose (Hanrahan, 2009). I assumed that the ‘practice spaces’ for social care were known and identifiable, and as such, initially focused on the gap between the two learning contexts. Holistic single case study research (Stake, 2006) was proposed as the most relevant design to elicit

the experiences of practice tutors⁵² in social care settings and educators based in a college. As I was located within an Institute of Education, the proposed units of analysis included the social care programme in my workplace, the Institute of Technology Blanchardstown, and the practice tutors (employed) in this context/setting. In order to select appropriate practice settings, I needed to devise some criteria for the selection of suitable spaces, given that social care has evolved into a diverse range of care settings.

It was at this point the questions emerged ‘what do social care workers do?’, or ‘how they experience practice in different settings?’, or ‘how they are identified in these diverse services?’ (Hanrahan, 2009, 2016; Hutchinson, 2017). Moreover, the focus of this research was also predicated on the fact that researchers on social care practice within an Irish context tend to locate their studies in one setting, as the work of Graham (2011), Byrne (2014) and Brown (2017) in residential care, and Finnerty (2012) in the disability services illustrates. Whilst a growing body of literature in Ireland is emerging from the perspective of the worker in practice (Howard and Lyons, 2014; Lancaster, 2014; Brown, 2017), there is no Irish study presenting an overview of the contexts of care, or research on how the SCW’s experience of practice may differ between the settings.

In the research journey, the process of discovery can sometimes bring you back to the beginning, but with renewed focus and new knowledge. I was initially unsure if case study research was still the most relevant approach because the research question had changed. However, what attracted me to case study research, and my desire to

⁵² Practice based supervisors of social care students during the practice placement.

“understand a real-life phenomenon in depth” (Yin, 2009, p. 18), was still relevant to the renewed focus of this study. For this study, the *holistic multiple case study approach* was deemed most applicable to elicit the experience of individual social care workers in diverse contexts. This research is constructivist and aligned to the case study approach of Stake (1995, 2006, 2010) and Merriam (1997, 2009). According to Merriam and Tisdell, it is “the units of analysis *not* the topic of investigation, which characterises a case study” [original emphasis] (2016, p. 38). In this case, it is the social care workers’ individual experiences of practice, that are the focus of study. The rationale for this decision is explored in detail later, as this chapter continues by establishing the principles of case study research as a paradigmatically aligned and relevant methodology.

4.2.3 Engagement of the Integrated Theoretical Framework

This study is viewed through an integrated lens of sociocultural theory, social pedagogy and sociopolitical theory. Discussed in Chapter One the theoretical lens of sociocultural theories (specifically situated learning) and social pedagogical lens of head, heart and hands, supports the discourse on situated, holistic, relational and embodied practice. Sociocultural theory is applied to diverse fields of research including social care (Gallagher and O'Toole, 1999; McSweeney, 2011), and research using a case study method (Meyer, 2001; Ozfidan, Machtmes and Demir, 2014). As Schoen (2001, p.13) stated, irrespective of the field or research design, all sociocultural research must acknowledge at least two of the three domains which are “believed to influence human behaviour in socially situated contexts”. These three domains are the social, individual and cultural (Vadehoncoeur, Velloso, and Goessling,

2011). This research aims to examine workers' experience of practice in diverse settings by exploring how engaging, participating, and negotiating with others influences their identity formation and the symbols and meanings they employ in practice (Wenger, 1998). Irrespective of the setting, social care workers are directly involved with people using assessment and planned interventions to provide for the holistic needs of diverse and vulnerable populations (Lalor and Share, 2013). Social care work is relational (Fewster, 2013). Hence, learning is based on interactions between the worker, the service users and his or her colleagues.

While overarching ideologies have been examined in Chapter Two, Michel Foucault's concepts, in particular the power mechanisms that control and discipline the subject through self-surveillance, examination and regulation (Foucault, 1977/1995), will be used to explain the everyday influence of neoliberalism and the mechanisms from new managerialism on the three domains of social care practice in Ireland. Jones and Ball (1995) argue that Foucauldian concepts are applicable to research with an "emphasis upon case study and context, the language of actors' meanings...and a commitment to understanding and description rather than explanation and cause" (Jones and Ball, 1995, p. 46). Finally, researchers Chavaudra et al. (2014) performed a holistic case study on services for children that used a social pedagogical model⁵³. Case study research enabled Chavaudra et al. (2014) to collect data using multiple methods. The three theoretical lenses are suitable frames for a constructivist, qualitative study using a case study research methodology. With the

⁵³ This study examined the suitability of social pedagogy as part of a framework aimed to improve the outcomes for young people in Derbyshire, UK, and the initial findings suggest that where social pedagogy is applied, the educational attainment of the young people improved (Chavaudra et al., 2014).

significance of the integrated theoretical lens outlined the chapter continues with the first two stages of Yin's (2009) framework the plan and design of this study.

4.3 Case Study Stages One and Two: Planning and Designing

Case study research belongs to the constructivist paradigm (Mertens, 2010a; Baxter and Jack, 2008), and is described as both a research approach and a research method (Simons, 2009; Yin, 2009; Mertens, 2010a). Although defined as a qualitative research method (Mertens, 2010a; Baxter and Jack, 2008), case study research can include both qualitative and quantitative data (Simons, 2009; Yin, 2009). Simons (2009) provides a comprehensive analysis of case study research in her text *Case Study Research in Practice*. Her book presents the evolution of definitions for case study research from the key theorists; MacDonald and Walker (1975), Merriam (1988), Yin (1994) and Stake (1995). Merriam and Stake focused on the importance of studying the singularity of a case, either through a single case study or a limited number of cases, which encourages an in-depth analysis (Merriam, 1988; Stake, 1995). MacDonald and Walker (1975) included 'action' or 'activity' in their definitions to highlight the context being a real life phenomena. Yin's (2009) definition encompassed the relevance of real life contexts with an acknowledgement that the relationship between the case and the context is also relevant.

- "A case study is an empirical inquiry that
- investigates a contemporary phenomenon in depth and within its real-life context, especially when
 - the boundaries between phenomenon and context are not clearly evident"
- [original formatting] (Yin, 2009, p. 18).

Although Yin's approach to case study research is defined as having positivist leanings (Yazan, 2015), "both Stake (1995) and Yin (2003) base their approach to case study

on a constructivist paradigm” (Baxter and Jack, 2008, p. 545). Merriam (2009) wanted more structure in her approach to case study research, and as a result, she adopted a combination of Yin and Stake (Yazan, 2015). The twenty-six social care workers are defined as individual ‘cases’ within this study in adherence to the case study approach and to emphasis the complexity of each case which includes the experience of the individual worker and the specific context in which they work (Yin, 2009).

4.3.1 The Plan: (Re)establishing the Rationale and Research Question

Case study research supports an in-depth analysis of a specific case, or cases, on a case-by-case basis, and social care practice is a contemporary phenomenon worthy of comprehensive investigation (Feagin, Orum and Sjoberg, 1991). The practice occurs within real life services providing care for people in society, and the case study approach facilitates an experiential understanding of the places of human activity (Stake, 2010).

As well as wanting to understand the worker’s experience of practice, this study is also focused on the relationship *between* practice and the context (social care service), and case study research facilitates this. By employing a case study approach, there is scope to explore the meanings people share about their lived experiences of practice. By employing this method the in-depth descriptions and meaningful details begin to emerge (Stake, 1995, 2006). To summarise, case study research is suited to research asking ‘*why*’ or ‘*how*’ questions, it is situated in a context(s) and bounded by time and space, (Merriam, 1997; Yazan, 2015). Case study research is also an in-depth qualitative study of specific cases using multiple methods of data collection (Stake,

2006; Yin, 2009). Thus, the descriptive and explanatory question of ‘how social care practice is experienced in different spaces’ is methodologically aligned to the case study approach and the integrated theoretical lens.

4.3.2 Case Study Research - Stage Two: The Design

The design stage begins by selecting the method of case study research most appropriate to the research question. Case study research can be a single in-depth study of one person, place or organisation (Simons, 2009) or a multiple study of similar cases (Stake, 2006, Yin, 2009). For multiple case studies, there must be some commonalities between each case, something they all share. As this is a study of social care workers’ experience of practice in different settings, the multiple case study is preferable. Yin (2006, 2009) asserts that as with single case studies, the multiple case can be embedded⁵⁴ or holistic. Holistic case studies define a study using one unit of analysis in one context, whereas in an embedded case, the study would include more than one unit of analysis in each context. This study is a holistic multiple case study as the units of analysis (social care workers) are singular studies in different contexts (twenty-six practice settings).

Studying one worker from each context potentially facilitates a greater breadth and scope of practice areas. Although the workers are situated within different services, they are all qualified social care workers. According to Stake (2006), there is a struggle for attention between each case and the overall multicase research project. Stake (2006, p. 1) states that in multi-case studies, a tension exists because the researcher must focus on one case at a time whilst maintaining an overview of the

⁵⁴ If several workers in the study are from one service, the case study approach is ‘embedded’ (Yin, 2009).

‘quintain’ or common theme between multiple units of analysis, referred to as the ‘case-quintain dilemma’. Structuring the twenty-six cases into case clusters (see section 4.6.1) helped the study of “what is similar and different about the cases in order to understand the quintain [what is social care in diverse settings] better” (Stake, 2006, p. 6).

4.3.3 Case Selection: Selecting the Units of Analysis

Case selection in this study requires a balance of range to allow cases deemed as representational of practice settings (residential care for children and the disability services) and those that are less known to emerge (Stake, 2006). Thus, to identify cases within historical and emerging settings, purposive sampling (Mertens, 2010a) and snowball sampling (Denscombe, 2003) were utilised to aid the selection process. Purposive sampling or purposeful sampling (Maxwell, 2013) is the process of targeting the specific people relevant to the research question; qualified social care workers. Snowball sampling defines the practice where one participant will recommend a suitable other for the study (Silverman, 2000). The actual number of social care workers in Ireland is currently unknown, although the Health Service Executive HSE (2009, p.40) stated that there were 3,367 social care workers in Ireland. What is not clear is the number of workers in private agencies and non-statutory services. Also, until the ‘Social Care Registry’ is established, the settings employing social care workers are not definitive. Table 4.1 highlights the categories of social care workers who have become members of the professional representative body for workers, educators and managers of social care. The sample is representative of

social care practice in Ireland based on the membership of SCI⁵⁵, as a guide for the practice areas employing social care workers currently.

SCI Membership Categories and Settings	Full	Assoc.	Student	1st year	Total membership by Specific Setting
Addiction	1				1
Aftercare	4				4
Ageing	4		1		5
Children and Families	33	4	4	3	44 (21%)
Disability	54	9	15	5	83 (40%)
CAMHS/mental health	8		2		10
Homeless Services	8		2	2	12
Special/Secure Care	2				2
Management	8	1	1	1	11
Education	9	10		1	20 (9.5%)
Other	6	1	8	1	16
Total membership by Category	137	25	33	13	208

Table 4.1 Member Categories and Sectors of Social Care Ireland 2017

As is evident from Table 4.1, social care is varied. Therefore, it was essential to engage a variety of experiences from as many different practice settings as possible. Thus, the sample was selected purposefully, screened for suitability (Yin, 2009), and opportunistically and voluntarily recruited (Mertens, 2010a, p. 322) from within Ireland. As Wenger (1998) stated, learning how to master practice takes time, and as such, only social care workers with a minimum of five years' experience, with two of these years being in their current setting, were invited to participate. Yin (2009) recommends between 20-30 participants for a multiple research study. It is important to note that case study research "is not sampling research" and therefore the aim is not

⁵⁵As a reminder, SCI Social Care Ireland is the professional representational body for all social workers, managers and educators in Ireland.

“to understand other cases” (Stake, 1995, p. 4), it is to understand the units of analysis in greater detail. The main participant recruitment sources included one advertisement in the *Curum*, a newsletter published by the Irish Association of Social Care Workers IASCW for social care workers, and by open invitation to the delegates at the 2014 Social Care Ireland [SCI] conference. The *Curum* route yielded eight responses from participants in the Midlands, Leinster and the South West of Ireland.

At the 2014 SCI conference, the advertisement was one of three research studies included as supplementary reading in the conference pack. During my Presidential Address, I referred to the research by reminding delegates about the several requests for research participants within the packs. The ethical considerations of my approach to sampling are discussed in section (4.5.5) of this chapter, specifically, the potential misuse of power when I invited research delegates from the professional body Social Care Ireland during my tenure as President. The research was also discussed during my informal conversations with managers and workers over the three-day event, which generated much interest in the project. The combined effort yielded twenty-two responses, and the remaining four participants became aware of the study through the involvement of a peer, or snowball sampling (Maxwell, 2013).

4.3.4 Units of Analysis –26 Social Care Workers

The twenty-six participants in this study were situated in different settings with the most common being the disability sector and residential care for children, see Table 4.2 on the following page.

No	M/F	Alias	Service	Current Job Title
17	F	Michelle	Day Service Adolescent Mental Health	Social Care Leader
23	F	Samantha	Mental Health	Social Care Worker
2	F	Mary	Residential Care for Children	Social Care Worker
8	M	Adam	Residential Care for Unaccompanied Minors	Social Care Worker
14	F	Sarah	Residential Service for Looked after Children	Regional Manager for Children Services
16	M	Eddie	Residential Group Home for Children	Social Care Manager
18	F	Emma	Residential care home for Children	Social Care Manager
3	F	Amanda	In-House Training for SCWs	Training Officer
4	F	Joan	Young Adult Community Crime Prevention Project	Project Coordinator
5	F	Alice	Day Activation for Adults with Intellectual Disabilities	Senior Supervisor
9	F	Kate	Day Service for Acquired Brain Injury	Facilitator
10	F	Laura	Day Services for Adults with Intellectual And Physical Disabilities	Social Care Worker
20	M	Liam	Outreach in Disability Service	Outreach Regional Coordinator
6	M	Jim	Homeless Service Residential	Social Care Worker
19	M	Colm	Residential Homeless Sector	Social Care Manager
21	M	Frank	Homeless Service Aftercare Team	Aftercare Worker
24	F	Bernie	Homelessness Residential	Project Worker
25	F	Clare	Homeless Residential	Project Worker
1	F	Paula	Residential Care for Children with ID	Social Care Worker
13	F	Una	Residential for Children with Sensory Disability	Social Care Leader
7	M	Simon	Intellectual Disability Residential (Adult)	Social Care Leader
11	F	Rita	Residential for Adults with ID	Social Care Leader
12	F	Olivia	Residential for Adults with Autism	Social Care Worker
15	F	Ava	Residential for Adults with an ID	Social Care Leader
22	F	Joanie	Addiction	Project Worker
26	F	Sheila	Addiction	Case Worker

Table 4.2 Current Job Title and the Location of Practice

The study aimed to engage a diverse sample of social care practice settings. As already discussed, the case selection of twenty-six workers is not a definitive list of all the possible care settings employing social care graduates. As alluded to above, all twenty-six participants were qualified social care workers with a minimum of five years' experience and at least two years' practice in his/her current setting. Twelve of the participants are in a management role and the remaining thirteen work 'on the floor'. One participant (pseudonym Amanda) works in training for the Health Service Executive, providing in-house training for social care workers in practice. The decision was made to include Amanda in the study because of her previous experience in social care (20 years in children's residential care), and to explore broader issues around what constitutes a 'social care worker'.

Although all participants are qualified social care workers⁵⁶ and were employed based on their social care qualification, they are also categorised in Table 4.2 by title, which was also relevant to the worker's experience of practice; social care worker (n=8), social care leader (n=5), social care manager (n=2), project coordinator (n=1), senior supervisor (n=1), regional manager (n=1), facilitator (n=1), project worker (n=3), case worker (n=1), aftercare worker (n=1), training office (n = 1) and outreach worker (n=1). As part of the design stage Yin (2009) recommends establishing propositions based on the relevant literature.

⁵⁶ Qualified Social Care Workers -each participant has an approved qualification based on the current legislation, the Health and Social Care Professionals Act (2005).

4.3.5 Propositions

All case study research begins with a thorough examination of literature pertaining to the research theme (Tellis, 1997). Propositions are the hypothesis of what may emerge from a review of the literature and the researcher's knowledge of the area in question (Simons, 2009) and they establish the areas requiring further explanation. Table 4.3 highlights the propositions established from the literature review, presented under the three themes of this study; practice, worker identity and context.

Propositions from the Body of Knowledge for Social Care Practice (Practice, Identity and Context)	
Trajectory	Literature Review
Practice	The significance of the integrated lens of Head, Heart and Hands (Pestalozzi) (Digney and Smart, 2014), situated learning, specifically 'regimes of competence' (Lave and Wenger, 1991; Wenger, 1998) to the standards of proficiency (CORU, 2017b). To explore how practice is influenced by the mechanisms of new managerialism from a neoliberal welfare regime and the significance of Foucault's (1977/1995) idea's on disciplinary power to the influence of the dominant ideologies.
Propositions on Practice	Social care work is relational and a balance between the use of self (heart) and use of skills (hands) and knowledge (head). There is situated knowledge and meanings created within specific settings. Practice is influenced by dominant and residual ideologies especially neoliberalism.
Identity	Understanding identity and professional identity. Multiples of titles used in practice. History and evolution of social care education. History and evolution of social care (child care to social care), professionalism and accountability. Relational Work, embodiment, Journey into care, the role of personal story as a motivator.
Propositions on Identity	Identity is diluted by multiple titles in practice and education. Identity is significantly defined by the practice setting.

	Workers identity is located within stories of practice and relationship with service users.
Context	Introducing Social Care Settings, Space and Place (Taylor, 2013), figured worlds (Holland, Lachicotte, Skinner, and Cain, 1998), rituals in context, material culture, embodiment in the setting. Structures (medical versus social, regulation HIQA, the challenge of culture /acceptance of violence and assault). Education Context and how it defines practice settings (HETAC Standards, policies, CORU, standards of proficiency, academic frameworks and relationship to practice). Purposeful use of ordinary places.
Propositions on Context	Social care has expanded into a variety of services, which are developed to meet needs. Social care workers learn about practice through their participation with others in the setting. The architecture and material culture influences the experience of practice. There are definable practice spaces within each setting.

Table 4.3 Theoretical Propositions emerging from the Literature

4.3.6 Establishing Rigour in Case Study Research

Traditionally described as a ‘soft’ method (Yin, 2009, p. 21), Merriam (1997, 2009) argues that case study research is difficult to apply, and as such, the researcher must establish rigour through all stages, from the research design to ethical consideration guiding the data collection process through to the analysis process and storage of the chain of evidence. According to Eisenhardt (1989, p. 546) criticisms of case study research claim that “the process is limited by investigators preconceptions, in fact, just the opposite is true”. The theoretical propositions outlined in Table 4.3 which emerged from the literature presents one reality, which is juxtaposed and compared across cases

and between cases to the other realities emerging from the data (Eisenhardt, 1989). This process enhances rather than limits the analysis of the data.

Patton (2015) states there are four different types of triangulation which are relevant to research: data triangulation, investigator triangulation, theory triangulation and method triangulation. In this case, data triangulation is applied to the transcribed text of twenty-six qualitative focused interviews; photographs provided by the participants through photo elicitation (Harper, 2002); verbalised text on the participants' interpretation of the image they were shown during the interview process (Rose, 2016) and finally, the practice stories workers shared (Dwyer, Davis and Emerald, 2016). Theory triangulation relates to the application of varied theoretical views to the same data, which includes sociocultural theory, sociopolitical theory and social pedagogy. Triangulation is not just for the purpose of finding similar results, but to demonstrate *how* interesting and thought-provoking findings can emerge from the data (Patton, 2015), through both deductive and inductive coding of thematic analysis (Braun and Clarke, 2006). Furthermore, rigour is achieved through a clear presentation of this multiple 'chain of evidence' (Yin, 2009, p. 3), and through the preparation processes initiated before data collection, including the adherence to ethical codes of research practice.

4.3.7 Ethical Considerations, Implications and Clearance

All research is governed by codes of good practice, which include the ethical responsibilities of the researcher towards the participants they engage with, and the information they collect. All research carried out in the University College Cork UCC

must adhere to the *UCC Code of Research Conduct* (University College Cork 2010), and the ethical guidelines set by the specific Ethics Committee approving the study. In UCC the Social Research Ethics Committee (SREC) approves all studies of “non-clinical research involving human participants” (University College Cork, 2010, p. 3), which aims to avoid harm and “minimise the potential risks and maximise potential benefits to research participants, where the benefits...outweigh the risks” (UCC, 2010, p. 9). I was granted approval from the Chair of the Social Research Ethics Committee on the 16th of May 2013 (Appendix 1). As the focus of the research changed from pre-service education to learning on practice, SREC granted approval for the revised research proposal on the 5th of March 2014 (Appendix 2), which also included the additional use of photographs for triangulation of data sources (Simons, 2009; Mertens, 2010a).

This research study also adhered to the principles of best practice from the British Psychological Society’s Code of Human Research Ethics (2010), especially my social responsibility to acknowledge potential risks and to do no harm. The British Educational Research Association’s research code of conduct was also considered, which emphasises respect though having an awareness “of confidentiality and maintaining the anonymity of the participants” (BERA, 2011, p. 5). Respect is evident through the practice of obtaining informed valid consent (The British Psychological Society, 2010) from the participants before engaging in the data collection. In this study, all the participants had the capacity to provide informed, valid and documented consent in their first language, without pressure, and were made aware of their right

to refuse to participate in the study at any stage. The interviews were transcribed⁵⁷ using the guidelines proposed by Humble (nd), and I checked each transcription for accuracy to the original recordings. The transcribed interviews were also returned to the participants for review, and as a result of this process, four transcripts were amended by participants prior to their inclusion in the study. All participants were informed in writing of how the interview was recorded and stored and that they can withdraw at any time, up to the submission of the study. According to University College Cork *Code of Research Conduct* (2010, p. 15) all data “be securely held for a minimum period of ten years after the completion of a research project”. See (Appendix 3) for the information pack and letter of consent.

Malone (2003) and Williams (2009) expressed concerns over the ethical implications of doing research in your ‘own backyard’, and asserted the importance of being reflexive⁵⁸ during the research process. Interestingly, Williams (2009, p. 214) also made reference to the ethical dilemma facing the researcher when they uncover ‘guilty knowledge’, “when what we learn can have consequences”, for example, when workers talk negatively about experiences in private services, for instance, they could be talking about one of my colleagues⁵⁹ in Social Care Ireland. Moreover, there are also ethical issues about the interviewer/interviewee relationship, and the possible role of relational power and influence over the voluntary participation of the respondents. As Finlay (2009, p. 162) contend, “when gathering data, researchers face ethical challenges relating to the use and (misuse) of power”. As President of Social Care

⁵⁷ The interviews were typed by a transcriber who followed the guidelines of Humble (nd) and the transcriber also adhered to the ethical guidelines of confidentiality outlined within this chapter.

⁵⁸ The process of being reflexive is discussed in greater detail later in this chapter in subsection 4.5.6.

⁵⁹ Social Care Ireland SCI is comprised of Managers, Educators and Workers, owner/managers of private care services are equally entitled to join SCI. At the time of publication there are currently two managers from private residential services on the Board of Directors of SCI 2014 -2018.

Ireland during the data collection stage of the research process, I need to acknowledge the potential influence of this role over the voluntary participation of participants in this study, as a limitation. Stahl (2004, p. 292) specifies that the invitation should be “without undue pressure” and as leaders are more likely to influence others (Bass and Bass, 2008), this potential influence is raised here as an ethical issue. Also, as I recruited some participants from the SCI conference, it is possible that these workers are potentially more professionally active, experienced and engaged than other social care workers in Ireland.

There is a balance between risk and benefit. However, the “emergent nature of qualitative design precludes researchers being able to predict where the study will take them” (Malone, 2003, p. 800). Any information that the participant shares “has the potential for harm” (Williams, 2009, p. 214) and it is the responsibility of the researcher to protect the participants’ anonymity through every measure possible. Direct observations are one of the preferred methods of data collection within case study research (Eisenhardt, 1989; Stake, 1995; Yin, 2009). However, it is important to note that social care involves relational work with people, based on a relationship of trust, established over time (Kroll, 2010). Due to the sensitive and intimate nature of the work, and given time constraints/limitations of this study, it was decided that to minimise potential harm to the service users, focused interviews were favoured over direct observations, as the preferred data collection tool. Moreover, field-notes and memos⁶⁰ taken on the informal observations of the worker during the interview process can also support the analysis of the text and provide depth (Stake, 2006). I

⁶⁰ Observations made during the interview can include the types of pauses taken, eye-contact and changes in body posture (Stake, 2006). All observations made during the interview process were also noted and recorded as memos, an acceptable ‘data type’ of case study research (Mills, Durepos and Wiebe, 2010, p. 801).

explained the role of note-taking at the beginning of the interview, and in what way it will be used in the future to inform the data, and/or be published in the final report (Baxter and Jack, 2008).

As the data in this study included photographs as well as transcribed text, there is an ethical concern around the possible identification of the service, the participant and most importantly the services users who attend the service (Tinkler, 2013). The main concern for the use of images in research is how the researcher will protect the anonymity of the participant if his/her practice space is recognisable in the photographs (Frith et al., 2005). This is especially relevant to social care as the community is so small, there is a greater risk that the service may be recognised. To protect the participants' anonymity, I only included photographs of a room without people present, with no identifiable signs or landmarks, and only those with limited personal objects on show. Another ethical consideration is an awareness of possible biases throughout the research process, discussed in the next section of this chapter through the role of reflexivity.

4.3.8 Reflexivity

Reflexivity is evident throughout this study, from the introductory chapter highlighting the rationale for the research question, my decision to select a methodology that provides an in-depth account and insight of the lived experience, and the inclusion of arts-based methods. Etherington (2004) describes 'reflexivity' as a concept with multiple meanings. It is more than a tool used to enhance the rigour of the research (methodological reflexivity) (Etherington, 2004), as it also relates to an

awareness of the underlying assumptions, the roles and aims of the researcher (epistemological reflexivity), and their personal experience of the discipline being explored (Finlay, 2012). According to Willig (2013, p. 10), “there are two types of reflexivity; personal and epistemological”. Personal reflexivity was expressed within Chapter One, where I identified as a member of the social care community. My political inclination against the privatisation of care was evident in Chapter Three when I explored my personal biases about social care and how they may have influenced the research. Epistemological reflexivity is apparent through the illustrations of my visceral experience of learning and engaging with the lived experiences and stories of practice.

As noted, reflexivity is defined as an understanding of “what shapes our research at the time of conducting it” (Mauthner and Doucet, 2003; p.415). This relates to our feelings, bias, political ideology, gender, knowledge construction of the context being researched, our previous experience of the case (Finlay, 2012), to name a few of the possible influences on data collection and analysis. As a social care worker, researching social care practice, I bring my preconceived ideas about practice to the research. I interviewed workers from similar practice areas to my early career as a social care worker, so it was essential for me to be mindful of my emotions during those interviews and be aware of possible projections from my previous practice experiences (Ward, 2010). The role of reflexivity in research is to identify potential bias amongst other roles, in order to perform rigorous and effective research. Yin (2009) did not allude to the importance of reflexivity in case study research. However, Stake (1995, 2006) and Simons (2009) both stressed the importance of identifying

values and discussing how these values have influenced the decisions made from the research design, and the data collection, through to the interpretations made.

4.3.9 Limitations of Case Study Research

The advantage of case study research is the flexible nature of the approach and its suitability to all methodologies (Yin, 2009). There are also limitations to case study research, which are necessary to consider when using this approach. They are viewed as too lengthy and time-consuming, are deemed too limited to afford any generalisations, and are considered too difficult to do correctly (Simons, 2009). The time available may also limit the number of cases a single researcher can collect without compromising the quality (Mills, Durepos and Wiebe, 2010). Jackson (2010) warned about the potential for research bias in case study research, with researchers favouring cases that support personal views. Also, Jackson (2010, p. 102) stated that the cases selected may be “atypical and any generalisations made to the general population would be erroneous”. These limitations are reduced through a rigorous approach to the process of case study research, reflexive awareness and adherence to ethical codes of behaviour and a triangulation of data sources. The chapter continues with the preparation stage of the research process.

4.4 Case Study Research - Stage Three: Prepare

The preparation stage of case study research establishes a foundation for the data collection and analysis process. Preparation is guided by the case study protocol and the pilot study. According to Mills, Durepos and Wiebe (2010) case research is a

challenging methodology that demands the researcher be a good listener, have an in-depth knowledge of the phenomenon, be flexible to follow the participants' story without bias, and be unbounded by personal preconceptions, or those based on the literature. This requires an inquisitive mind and ability to listen to the story "between the lines" (Yin, 2009, p.72). Central to the planning stage is the creation of the case study protocol.

4.4.1 Case Study Protocol

The case study protocol is essential for researchers doing multiple case studies, as the protocol outlines the structure being used and the procedures the researcher will follow, which increases the reliability of the study. In the case of this study, this methodology chapter follows the guidelines of the case study protocol. According to Mills, Durepos and Wiebe (2010), a case study protocol begins with the research question and the propositions identified from the literature review. The protocol also includes the data collection procedures, comprising of the units of analysis and the chosen methodological tools (Yin, 2016). As well as selecting the people (cases), it is also essential to formulate a plan for the interviews, which includes the proposed interview questions. Stake (2006) asserts that a semi-structured interview protocol also aids the novice interviewer. All the information introducing the study is also an important part of this preparatory stage. See Appendix 3 for the consent form, interview question sheet and the information pack presented to participants before conducting the focused interviews. The next important preparatory stage of case study research is the pilot study.

4.4.2 The Pilot Study

I conducted two pilot studies in preparation for the data collection stage. The first study was a survey conducted with social care students returning from placement to ascertain the types of services employing qualified social care workers. The findings are included here as Appendix 8. The second pilot was a focused interview (Yin, 2006) with a social care worker to test the interview protocol and triangulation process.

Pilot Study for Focused Interview: I conducted one qualitative interview on the 25th of March 2014 to test the interview protocol, the timing and format of the focused interview, and the feasibility of the photo elicitation process (Merriam and Tisdell, 2016). The interviewee (pseudonym Ava), applied to her organisation for permission to participate in the pilot study and to take images of her practice spaces. Permission to engage in the auto-led photo elicitation process⁶¹ was declined by her internal ethics committee. However, Ava was granted permission to participate in the study and answer the researcher-led photo elicitation question (Jenkins, Woodward and Winter, 2008). Although Ava was unable to share images of her practice spaces, I decided to keep the auto-driven photo elicitation question in the study (Collier and Collier, 1986). Even if workers were unable to take an actual photograph of a practice space, the process of thinking about practice spaces might encourage a more prepared and in-depth discussion during the interview. With the case study protocol established, the next stage of the multiple case study is the collection of data.

⁶¹ There are two methods of using photographs in photo elicitation; auto-led is photographs taken by the interviewee and brought into the interview, and researcher-led relates to photographs introduced by the interviewer.

4.5 Case Study Research - Stage Four: Data Collection

Within qualitative case study research, the researcher has a choice between many methodological tools, for example, observations, audio and video recordings, focus groups and interviews, to name a few (Tellis, 1997; Silverman, 2000). The focused interview (Yin, 2009) was deemed the most appropriate methodological tool for this study. However, as an artist and art therapist, I am also aware of the potential of arts-based methodologies to elicit meanings within qualitative research (Margolis and Pauwel, 2011). By encouraging participants to include images of the spaces they use to engage with others or to visually describe the figured world of this practice (Holland et al., 1998) enhances the potential for rich data. Stake (1995, 2006, 2010), Baxter and Jack (2008) and Merriam (1997) all stress the value of multiple methodologies, so this study utilised two methods of data collection; focused interviews (Yin, 2006, 2009; Galletta, 2013) and arts-based research including photographs (Harper, 1988, 2002; Phelan and Kinsella, 2011), and stories (Sfard and Prusak, 2005; Mannay, 2016) to ascertain how qualified workers experience social care in a variety of settings. Drawings were also used to illustrate and support the interpretation of the world of practice (Mitchell, Theron, Stuart, Smith, and Campbell, 2011b).

4.5.1 The Qualitative Focused Interview

Twenty-six focused interviews were conducted between the 25th of March 2014 and the 15th of September 2014. All interviews were conducted in one sitting and the average interview was 1 hour and 10 minutes long. The interviews were recorded using a dictaphone, with permission granted from the participants. Since speech is punctuated with social and cultural cues or stylistic features such as accent, rhythm,

tone and speed, the use of a tape recorder proved invaluable. After the transcriptions and initial coding of the interviews, the participants were contacted by email to expand on their responses to one question; their identity when leaving college and entering the social care setting. Twelve responses were collected and subsequently added to the corresponding transcript for analysis.

The choice of using interviews in a qualitative study depends on the research question, the research design proposed, and fundamentally the worldview of the researcher (Silverman, 2000; Mertens, 2010a). The interview allows the researcher to ask questions that explore the participant's initial responses in greater detail (Simons, 2009). Seidman (1998) also states that interviewing gives the researcher an insight into the meanings people make for their world, behaviours and actions. Within the interview process, the researcher can apply a formal or unstructured approach, depending on the nature of the study. Interviews are subject to "common problems of bias, poor recall, and poor or inaccurate articulation" (Yin, 2009, p. 108), but are still viewed as a valuable data collection tool in case study research. The first interview technique for case study research is described as the *in-depth interview*. Simons (2009) favours this open-ended, unstructured interview technique as it allows the full 'story' to emerge. Although desirable, the in-depth interview requires the availability of participants for an extended period, which is an unrealistic goal for social care workers in the current climate of staff shortages and anti-social working hours. The second interview technique is the *focused interview*, which Yin (2009, p.106) described as a 'guided conversation' rather than being completely structured. It is shorter than the in-depth or open interview (Baxter and Jack, 2008) and useful when used to collaborate multiple views. The final interview technique *survey* outlined by Yin (2009) is more

structured and follows formal lines of enquiry. Surveys are suitable for the collection of quantitative data (Meyer, 2001) and were deemed not relevant to this study.

This study adopted the focused interview (Yin, 2009), which is similar in application to the semi-structured interview because of its versatility, where open-ended questions are loosely held within a formal structure (Galletta, 2013). “A key benefit of the semi-structured interview is its attention to [the] lived experience” (Galletta, 2013, p. 24) of the interviewee. Within the interview, open-ended questions encourage the interviewee to recall a situation and discuss the meaning of the phenomena. For example, describe a situation where you felt that you were doing social care work? The interview used ‘how and what questions’ (Yin, 2009; Silverman, 2017) to prompt the interviewee to reflect on experiences, actions and specific situations. The knowledge gained from the interview is described as “situational and conditional” (Rubin and Rubin, 1995, p. 39), and provides an insight to the meanings attached to actions in each situation, or under specific conditions. According to Brenner (2006, p. 357), the interview helps the researcher to understand the meanings created by participants to explain their world, and portray these meanings using their “own terms”. Defined as an interactional relationship, both the researcher and the participants are involved in the meaning making during an interview (Brenner, 2006). As discussed, meaning is not completely known or ‘transparent’ and so just asking the worker to describe how he or she may experience social care practice, may not elicit desired meanings. Understanding practice is a difficult process (Hutchinson, 2017), and as such, creative methodological tools were used in conjunction with the focused interview to elicit the meaning of practice, based on the research question.

4.5.2 Arts-Based Research Tools -Story, Drawing and Photo Elicitation

“The point is to access a different way of knowing through creative processes that engage the emotions and feelings and facilitate intuitive understanding of the data” (Simons, 2009, p. 5).

The 1980s marked the introduction of using creative arts in research (Cahnmann-Taylor and Siegesmund, 2008; Knowles and Cole, 2008), both as the focus of the research and as a methodological tool within research (Barone and Eisner, 2012). Discursive communication is limited, and arts-based research enables interviewees “to express meanings that otherwise would be ineffable” (Barone and Eisner, 2012, p. 1). A central aim of this research is to elicit the meanings workers attribute to the artefacts of practice (Reynolds and Herman-Kinney, 2003) and to understand how they define the practice space within different settings. Frith, Riley, Archer and Gleeson (2005, p.189) identified three benefits of using images in qualitative research; 1) to access meanings that may not arise through using other methods; 2) to provide a vehicle for the ‘voice’ of participants, and 3); to “enable both researcher and audience to widen their experience [and] understanding” of the case. People now live in an image and narrative filled world (Sekula, 1982; Frith et al., 2005; Tinkler, 2013), and arts-based methodologies will aid the comprehension of this new knowledge for the reader. Images and stories are complementary to the focused interview (Yin, 2009), and are a triangulation of rich, interesting and varied data (Patton, 2015). The arts-based research tools are discussed further here, beginning with the role of photographs in research and the relevance of photo elicitation to this study.

4.5.3 The Role of Photographs - Photo Elicitation

Photographs have become a popular way to capture minute-by-minute lived experience, especially since the development of the camera phone. Photographs prompt memory (Banks, 2001) and evoke increased meaning and perceptions (Margolis and Pauwels, 2011), capturing the lived history of the viewer. Photographs are not objective but are the subjective interpretations of how the world of practice is viewed by the participant (Jenkins, Woodward and Winter, 2008). Data findings presented in text form can be perceived as dull and uninteresting (Banks, 2001). However, the use of photographs in collaboration with the text promotes accessibility (Newby, 2014) and provides a visual representation of the context of the text (Frith et al., 2005). Frith et al. (2005, p.188) also challenged the increased reliance on language and text where only those with “knowledge of its language [have] clear access to the thoughts, ideas and experiences of others”.

Photographs are omnilingual⁶² and as such increase the likelihood of interpretation to a wider audience, and can help readers relate to the text and remember the context (Newby, 2014). At the 2014 Social Care Ireland Conference, Deirdre Byrne presented her research findings to a packed room⁶³. In her Irish-based study, photographs were used as a methodological tool to understand the role of the dining / kitchen table within residential centres for looked after children⁶⁴. The image of the dining table in the kitchen was the catalyst for analysis on what constitutes and means ‘home’ for both the young people and staff in the residential centre (Byrne, 2014).

⁶² This term relates to the ability to understand and/or speak multiple languages.

⁶³ The high level of interest in the use of images in Byrne’s study encouraged the use of images and arts based research in my study.

⁶⁴ An alternative term for children in residential care, for example Byrne (2014).

In Byrne's presentation, photographs provided a visual representation that enhanced the interpretations of the phenomenon, the role of the kitchen table, to the intended audience at the conference, social care workers and academics. By looking at the photographs of the many kitchen tables in Byrne's study, conference delegates could interpret which photo felt more like home or which image looked more 'institutional', a process of seeing and reading (Berger, 1972). As this study also aims to explore the spaces that social care workers 'work' in, which may include specific areas within the service or spaces outside the service that promotes relational work, the photograph was also deemed as an appropriate and illustrative/representational tool within this study.

There are many ways to use photographs in research, and the use of photographs within the interview is called photo elicitation. Photo elicitation is a research method applicable to case study methodology (Phelan and Kinsella, 2011). Photo elicitation is also suited to research examining the work environment or lived spaces of the research participant (Rose, 2016). Central to photo elicitation is the role the photograph plays in the construction of meaning, which "can prompt talk about different things, in different ways" (Rose, 2012, p. 305). The process of using photographs in the interview enhances the recollection of feelings that the frozen moment in time represents (Harper, 2002), the exchange "is stimulated and guided by the images" (Lapenta, 2011, p. 201).

"Photo elicitation evokes information, feelings, and memories that are due to the photograph's particular form of representation" (Harper, 2002, p. 13).

Photo elicitation uses photographs which are produced by the participant (auto driven), the researcher (researcher-led), or are already pre-existing (Phelan and Kinsella, 2011).

4.5.4 Auto Driven Photo Elicitation (Participant Led)

In the information booklet provided before the interview (see Appendix 3), social care workers were invited to provide photographs of the spaces they do ‘social care work’ in. This method was used to support the interview questions related to the context of practice. The photograph(s) taken by the participant provides an insight into their world as they see it and this tangible object enables the researcher to explore what the image means in greater detail (Harper, 2002). These photographs of ‘practice spaces’ may include areas where *indirect* work occurs, for example in the office where the worker completes paperwork or makes appointments for the service user (Fulcher and Ainsworth, 2012). The office may also be a space where *direct* social care practice occurs, in the form of a key-working session between the worker and the service user (Fulcher and Ainsworth, 2012). Depending on the setting, social care work may also involve driving the services user or engaging in recreational activities, such as having lunch together or going to the cinema. Through viewing images that are significant to the interviewee, the researcher gains access to the meanings workers have on the lived world of practice, and “meanings may be explicit or implicit, conscious or unconscious” (Rose, 2016, p. 2). Because of the emergent nature of social care, understanding the actual practice spaces of workers may provide useful insights to the specific context.

As alluded to in section 4.6.5, (ethical considerations), precautions must be taken to ensure that participants' anonymity is maintained within the study. However, when you include the images taken by participants of their practice spaces, identification is more likely (Inés Meo, 2010). Even though each of the five participants who provided photographs gave permission for the inclusion of the image in the publication of this study, it is the responsibility of the researcher to protect the anonymity of the participant (Malone, 2003). Bagnoli (2009) suggests that the images can be altered to make the photographs less identifiable, for example, by covering/blurring out social actors'/participants' faces, but this method was not needed here. The auto-elicited photographs were central to the interview process, and the participants were asked to comment and elaborate on the meaning of the photographs they shared. Although a small sample, the photographs were representative of the practice spaces identified by the majority of participants in this study. It is worthy of note that all participants engaged in the researcher-led photo elicitation stage of the interview, which demonstrates the value of using alternative methods of data collection.

4.5.5 Researcher-Led Photo Elicitation

In researcher-led photo elicitation, the interviewer brings a photograph into the interview, and the participant is asked questions about the image (Rose, 2001). The photograph used in this study was designed to metaphorically represent social care settings in Ireland. Participants were asked if the photograph (Figure 4.2) (the teddy and reading glasses) was an appropriate visual metaphor for their specific service.

Social Care

Learning from Practice

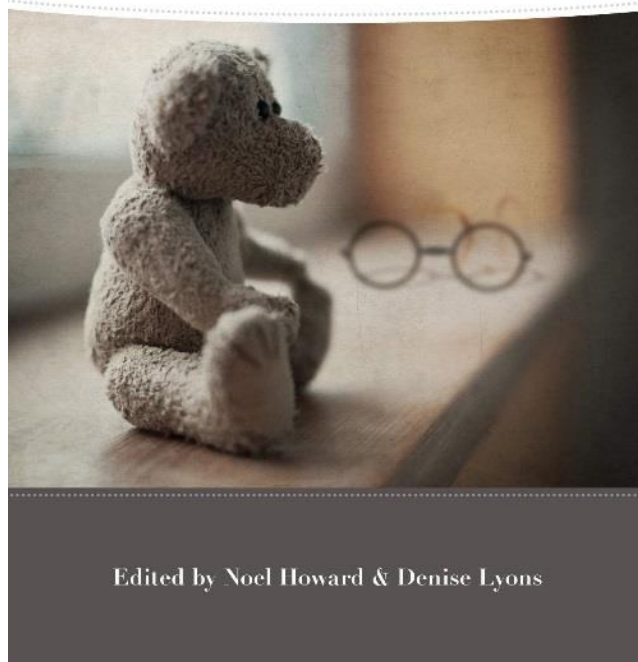


Figure 4.2 Book Cover ‘Social Care - Learning from Practice (Source: Denise Lyons)

The book cover Figure 4.2 was suggested by the publishers as a suitable metaphor for practice in diverse settings. Both Noel Howard and I were uncertain of the appropriateness of the symbols suggested. However, this ambiguity highlighted the multiple meanings of interpretation that images evoke, and the question of what image(s) social care workers might suggest as representational for his/her specific setting.

The participants described a variety of different ‘book covers’ to represent their practice settings, and I took notes of the facial expressions, body gestures, pauses and did some preliminary sketches of the imagined and figured worlds of practice. Holland et al. (1998) promote the benefits of exploring the potential and imagined spaces of the figured world. By encouraging workers to imagine and describe their view of the figured world of social care, this enhanced the description beyond the normal interview experience. Here workers brought to life “an atmosphere of possibility”, through the imagined and experienced figured worlds of practice (Holland et al., 1998,

p. 254). Sometimes knowing what something is not, or when it is “re-conceptualised as something else” (Brinkmann, 2012, p. 47) enables us to understand better what something is. This experience illustrated to me the value of using creative tools of data collection that we can understand the phenomena in-depth. The discussion on the role of creative methodologies continues with the role of story in research.

4.5.6 The Role of Story

Using story in qualitative research is core to narrative research, but its application as a field of study is contested, and definitions are ‘in dispute’ (Andrews, Squire and Tamboukou, 2013, p. 1). Dwyer, Davis and Emerald (2016) make a distinction between ‘narratives’ and ‘stories’. Narrative is a dialogue constructed to give meaning to an experience, whereas, story is the structure used to communicate an experience. The twenty-six participants of this study were invited to share two stories; 1) the story of their journey into the care profession, and 2) a practice story. “Stories are generated as reminiscences of how or why something occurred” (Hatch and Wisniewski, 1995, p. 13) and can provide an insight into unconscious formative influences and motivations. The relevance here is on how the past lives of social care workers have influenced *their* choice of profession, and to identify whether and how (their/subjective) past experiences provided a deep-rooted motivation to engage in caring work.

The story of practice enables an exploration of the identity adopted by the worker within the setting (Silverman, 2017) through the practice story. Simons (2009) encourages the researcher to view the practice setting as a story, with an embedded

narrative structure. Rooted within the narrative are “important values and attitudes, handed down as stories of individuals and as stories of experiences” (Bathmaker and Harnett, 2010, p. 161). The photograph and story play an equal role in the construction of meaning, and the representation of experiences of contemporary society (Rose, 2012; Andrews, Squire and Tamboukou, 2013). Krueger (1997) and Ranahan (2017) have used practice stories in their work to elicit the experiences of child and youth care workers. The chapter continues with the role of drawings in research and how I have used drawing within this study.

4.5.7 The Role of Drawings; Emphasis, Reflexivity and Analysis

“Drawing is a curious process, so intertwined with seeing that the two can hardly be separated” (Edwards, 1979, p. 2).

There are multiple examples where drawings are used to tell a story or to support the comprehension of a text, from illustrated children’s books up to graphic novels. This idea has a historical context, for example in the work of Victorian narrative painters, whose “pictures told a story using objects, clues, costumes, facial expressions, and the spectator had to become a detective, assembling the clues” (Wood, 2005, p. 1). The use of drawing as a research tool is one of the most utilised mediums in “several broad yet overlapping areas” of arts-based research (Mitchell et al., 2011a, p. 18). I have used drawing as a tool within this research as self-study and reflexivity, as emphasis and illustration, and for analysis⁶⁵.

For Illustration and Emphasis - Drawings are an excellent medium to clarify an aspect of the discussion (Mitchell et al., 2011b), or to illustrate an emerging theme

⁶⁵ Refer to Section 4.8.6 ‘Visual Reading’ for further discussion on how images are used for analysis.

(Edwards, 1979) or proposition from the literature review. Edwards (1979, p.224) in her text *Drawing on the Right Side of the Brain*, defined the use of pencil sketches within her text as ‘instruction-drawings’. Roam (2008) described the process of scribbling on the back of a napkin as a method of clarifying a thought of selling an idea. The image or drawing is a quick and effective method of showing others how you see the world. Roam (2008) uses the quick sketch as a communication tool which enables people to see the idea that was in his mind, to solve problems and look at big picture, through a process he coined as *visual thinking*.

“Visual thinking means taking advantage of our innate ability to see – both with our eyes and with our mind’s eye – in order to discover ideas that are otherwise invisible, develop those ideas quickly and intuitively and then share those ideas with other people in a way that they simply get” (Roam, 2008, p. 5).

There are several drawings throughout this thesis which are used for illustration and emphasis.

Self-study and Reflexivity – In case study research Simons (2009) describes the importance of using creative expression to illustrate disciplinary and epistemological reflexivity (Etherington, 2004). As an artist, visual mediums offer a natural form of personal reflection on my PhD journey. Simons (2009) suggested that all researchers should keep a reflexive journal or write a reflexive poem to aid the process of self-awareness. Simons (2009) also encouraged case study researchers to use memos throughout the data collection process, “allowing space for unconscious thought, drawing sketches and maps at different stages of understanding” (Simons, 2009, p. 142). I used drawings in the form of visual memos to allow the unconscious to flow (Malchiodi, 2013), to help me clarify a point (Edwards, 1979), or to help me see beyond the text to the big picture, the focus of the research. Smithbell (2010, p.

1597) was intrigued by the use of images in research, asking “Is art the data? The data-collecting instrument? The analysis?”. In arts-based research, it can be all three, and this chapter continues with the final stage of Yin’s (2009) model of case study research; the analysis stage, which includes a discussion on the use of drawing, coined as *visual reading* for analysis.

4.6 Case Study Research – Stage Five Analysis

Data analysis occurs from the beginning of data collection within this approach to research (Silverman, 2017) and right up to the end of the research process, after the plan, design, preparation, and collection stages are complete. Yin (2009, p.126) stresses the importance of using an ‘analytic strategy’ for the data analysis of qualitative case study research, which includes the thematic analysis of deductive coding (driven by the propositions, see Table 4.3) and inductive coding (dictated by the emerging themes). Analysis of the visual text (photographs and drawings) concentrated on the structure, context and visible characters and emerging themes under the guidance of Rose (2001, 2016), Keats (2009) and Kaplan (2014). Braun and Clarke’s (2006) six phase guide to *thematic analysis* was utilised to frame the study of both textual and visual data, supported with the aid of NVivo qualitative analysis software (Bazeley and Jackson, 2013). Also, to support the cross-case analysis of practice and context, the individual cases were grouped into ‘case clusters’ which minimised the potential for focusing on one individual case over another in a multiple case study.

4.6.1 Three Case Clusters: Deserving/Undeserving/Social Model

Social care in Ireland is a hybrid of ‘historical approaches’ (Hutchinson, 2017) to the care of both the deserving and undeserving in society (Lorenzen and Lake, 1987b; Byford et al., 2010; Garthwaite, 2011). All care sectors⁶⁶ represented in this study originated from an ideology of charity, volunteerism and Catholic state familialism which outsourced care to the Catholic Church (Magray, 1998; Blasi, Turcotte and Duhaime, 2002; Gilligan, 2009). The clustering of particular services to analyse social care *practice and context* (but not social care workers’ identities, see Chapter Five) is based on the originating relationship (Stake, 2006) of the service user to the historical ideology of care for those deemed ‘deserving or undeserving’ (Lorenzen and Lake, 1987b; Byford et al., 2010; Garthwaite, 2011). The twenty-six participants in this study, the individual cases (Stake, 1995; Yin, 2006) were categorised into three ‘case clusters’.

Case cluster one is the category of those originally deemed as less eligible or undeserving of care; the homeless and those addicted to drugs, which elicited a community response to care. Case cluster two is the opposite, and those deemed historically worthy of care, people with a physical or intellectual disability. This cluster was cared for by the state and the voluntary sector under a medical model of care. Child and Adolescent Mental health services are also included in this cluster based on the medical model of care provided (Kiely, 1999; Warren, 2005; Lalor and Share, 2013). The final cluster is children’s residential care which fell between the two perspectives, perceived as neither deserving nor undeserving and has evolved towards

⁶⁶ 25 different care settings. Amanda’s responses were included in Case Cluster Three -Children’s Residential Care, based on her previous work experience in this setting.

a social model of care. Table 4.4 presents the three clusters and includes the participants' pseudonyms, specific service area, and given title.

Group 1	Ideology of Undeserving Sectors: (Homeless Services, Addiction, Youth Crime Prevention)
Jim	Homeless Service Residential (Social Care Manager)
Colm	Residential Homeless Sector (Social Care Manager)
Frank	Homeless Service Aftercare Team (Aftercare Worker)
Bernie	Homelessness Residential (Project Worker)
Clare	Homeless Residential (Project Worker)
Joanie	Addiction Residential Service (Project Worker /Manager)
Sheila	Addiction Residential Service (Case Worker)
Joan	Youth Crime Prevention Project (Project Coordinator)
Group 2	Ideology of Deserving Sectors: (Disability Services, Child and Adolescent Mental Health)
Alice	Day activation for adults with ID (Senior Supervisor)
Kate	Day Service for Acquired Brain Injury (Facilitator)
Laura	Day services adults with ID and PD (SCW)
Liam	Outreach Disability service (Regional Coordinator)
Paula	Residential Care for children with ID (Social Care Worker)
Una	Residential for children with SD (Social care Leader)
Simon	Residential (Adult) ID (Social Care Leader)
Rita	Residential for adults with ID (Social Care Leader)
Olivia	Residential Adults with Autism (SCW)
Ava	Residential Adults with an ID (Social Care Leader)
Michelle	CAMHS (Social Care Leader)
Samantha	CAMHS (Social Care Worker)
Group 3	Social Model Sector: Children's Residential Care
Mary	Children's Residential Care (Social Care Worker)
Adam	Children's Residential Care (Social Care Worker)
Sarah	Children's Residential Care (Regional Manager)
Eddie	Children's Residential Care (Social Care Manager)
Emma	Children's Residential Care (Social Care Manager)
Amanda	In-house training for SCWs (Training Officer)

Table 4.4 Individual Units of Analysis Grouped by Originating Relationship to Ideology of Deserving or Undeserving

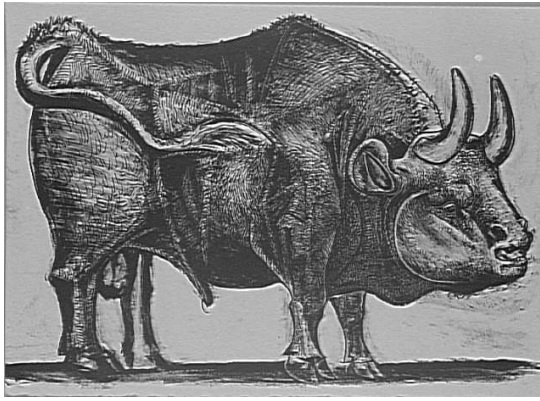
For much of the analysis, the case clusters worked well. If the response from an individual case was not similar to the cluster grouping, this was highlighted, and the

response was presented separately. For example, two social care workers from Child and Adolescent Mental Health CAMHS often spoke about their engagement in the relationship as therapy, so at times their responses appeared to conflict with the disability workers' experience of a relationship.

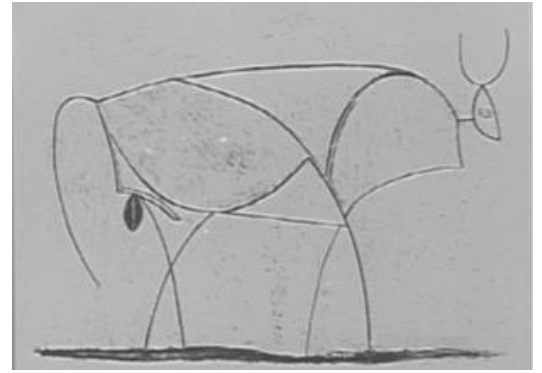
4.6.2 Thematic Analysis

According to Braun and Clarke (2006), thematic analysis is independent of theoretical paradigms. However, it is methodologically aligned to qualitative, constructivist research because it is a flexible tool which aims to provide rich data. As they assert “thematic analysis is a method for identifying, analysing, and reporting patterns (themes) within data” (Braun and Clarke, 2006, p. 79). Thematic analysis aims to reveal meanings by stripping back the layers of discourse and looking to the underlying themes, analysis at a latent level (Braun and Clarke, 2006). Pablo Picasso, in the eleven lithographs of *Bull* (1945 -1946), stripped back the image to reveal his abstract interpretation of the bull⁶⁷. Starting with a realist drawing in *Bull* Plate 1 and Plate 2, Picasso slowly reduced the use of line until he arrived at the abstracted shapes in *Bull* Plate 10 and *Bull* Plate 11. Using a metaphorically similar process, this approach applies thematic analysis as the method of stripping back and interpreting across the data sets to the meanings within.

⁶⁷ The use of Picasso's 'Bull' in this chapter was influenced by its similar use by Sadala and Adorno (2002, p. 284-285).



Bull Plate 2 (December 1945)



Bull Plate 10 (January 1946)

Figure 4.3 Bull Plates 2 and 10 (Source: Pablo Picasso 1945 - 1946)

Through thematic analysis, the textual and visual sources of data are analysed and viewed together as “one piece of the puzzle” and a thorough way of understanding the case (Baxter and Jack, 2008, p. 554). The researcher progresses from explaining the text to interpreting what the text means, to the final stage of analysis, which presents a new understanding of the world of the social care worker in a variety of settings. In good thematic analysis, the identified themes are representative of both a rich description and inductive interpretation of the data (Braun and Clarke, 2006). This process of thematic analysis enables the meaning of practice concealed within the dialogue and photo-elicited images to emerge. Through this process, the world of the social care worker and his or her experience of practice has moved from being unknown to a position that is both affirming and challenging the propositions made. Thematic analysis is the process of interpretation and a move from reading the text to an expounding of the meanings embedded within the visual and textual data. The six stages of thematic analysis proposed by Braun and Clarke (2006) include the following;

Phase 1: Familiarising yourself with your data. The recorded interviews were transcribed and read numerous times to generate ideas and initial themes. This stage is considered the ‘bedrock’ of the whole process of analysis and should not be rushed or skipped over (Braun and Clarke, 2006, p. 87). Initial themes under the trajectories worker, context and practice emerged.

Phase 2: Generating initial codes. The points of interest within each trajectory were gathered together into groups. This is a pre-interpretation stage and necessary to begin the process of identifying as many theory driven and data driven codes as possible for analysis in the next stage.

Phase 3: Searching for themes. This stage involved a “re-focuses the analysis at the broader level of themes, rather than codes” (Braun and Clarke, 2006, p. 89). The codes were re-collated under the emerging themes and defined as *candidate themes*. Visual mapping (see NVivo 4.9.3) was used here to see the links and relationships between codes and themes.

Phase 4: Reviewing themes. The topics were refined and linked back to the main themes; worker, identity, context, spaces, liminal situations, regimes of competence, relationships, the embodiment of head, heart and hands. It became apparent that some candidate themes did not have enough relevant data and examples to support the claims made and were subsumed into another theme. Braun and Clarke assert that at this stage in the research process, you should have a “fairly good idea of what your different themes are, how they fit together, and the overall story they tell about the data” (Braun and Clarke, 2006, p. 92).

Phase 5: Defining and naming themes. The refined and defined themes were discussed and linked back to the propositions (see Table 4.3) and viewed within cases and across cases. Braun and Clarke (2009) warn against viewing this as a process of paraphrasing the actual text. Rather, the aim of this process was to describe what is interesting about the theme and why. It was also important to review the sub-themes for the underlying meanings within the theme.

Phase 6: Producing the report. The report is the write-up and final stage of the research process which must be “concise, coherent, logical, non-repetitive, and interesting account of the story the data tells – within and across themes” (Braun and Clarke, 2006, p. 93). The argument for the hypothesis and claims made from the data, supported by relevant extracts from the transcribed text, stories and visual readings are presented in chapters five, six and seven. The analysis was supported through the use of a qualitative software programme NVivo.

4.6.3 Using Qualitative Software –NVivo

In this study (NVivo 10.0) was used as a tool to support the interpretation of 26 transcribed interviews (Bazeley and Jackson, 2013) framed by the six phases of thematic analysis (Braun and Clarke, 2006). Qualitative software does not analyse the data sets but supports the organisation of large volumes of text for analysis. NVivo helps by releasing “some of the time used to simply manage data and allowing an increased focus on ways of examining the meaning” (Bazeley and Jackson, 2013, p. 2). How the software complements the phases of thematic analysis is illustrated in Table 4.5 on the following page.

Overview of Thematic Analysis and Corresponding Process in NVivo			
Thematic Analysis			Corresponding NVivo Process
<p><i>From reading text to</i></p> <p>I N T E R P R E T A T I O N</p> <p><i>New understanding of visual and textual data</i></p> 	Phase 1: Familiarising yourself with your data	Transcribe the interviews. Read the transcriptions, and check against the recordings for accuracy. Take initial notes. Drawings made to illustrate the imagined spaces of practice. Visual reading - text from the imagined spaces are visually read.	Phase 1- Formatting transcripts, reading and re-reading the data. Theme: Worker – Identity, Journey into care, titles, identity in stories. Disciplinary power, ordering of the self. Theme: Context-spaces of practice, challenges, HIQA Theme: Practice-relational work, Head, Heart and Hands, emotional
	Phase 2: Generating initial codes	The initial codes may be theory/proposition driven (top down) or data driven (bottom up). Data organised into meaning groups. Drawings made to aid interpretation of the text, visual reading.	Phase 2 –Open Coding, reading and re-reading transcripts Phase 3 –Categorisation of themes ‘nodes.’ Phase 4 -‘Coding on’ –creating subnodes
	Phase 3: Searching for themes	What does the text say about the world of the interviewee? Looking to broader themes rather than codes. A thematic map is developed to look at relationships between themes. Themes are refined. Data is re-read to see if themes fit and what was missed.	Phase 5 –Relationships emerging between the themes ‘nodes.’ -Relationship of theories to data -Sociocultural – learning to practice, rituals and symbolic meanings, a cup of tea, shared time. -Social Pedagogy -trinity evident.
	Phase 4: Reviewing themes		
	Phase 5: Defining and naming themes	Define and refine the major themes. Do a detailed analysis of each theme and embedded sub-themes?	Phase 6 –Data Reduction Structuring nodes under three trajectories: worker, context and practice.
	Phase 6: Producing the report	Final analysis and write up “concise, coherent, logical, non-repetitive, and interesting account of the story” (Braun and Clarke, 2006, p. 100).	Phase 7 –Writing, validating and synthesising analytical memos.

Table 4.5 Thematic Analysis in NVivo.

NVivo facilitates the inclusion of data including text and images as a data source which was advantageous for this study, as “it offers many ways of connecting the parts of a project, integrating, reflecting and recording data” (Richards, 1999, p. 4). The researcher imports text and/or images into the program, and reads the text to find the embedded themes called *nodes*. Visual maps were also created within NVivo to see the relationship between the emerging nodes. As the text is read and re-read, the researcher can record ‘thoughts’ about the text as memos or *annotations*. In the process of reading the text within the software program NVivo, my thoughts about the text were recorded as ‘annotations’, which aided my interpretation of the text. These notes were linked to the original text, and they supported the process of interpretation. The chapter continues with a more detailed description of the processes involved in the analysis of interviews, transcribed text, life and work stories, photographs and drawings that became the rich data in this study.

4.6.4 Analysing Interviews and Transcribed Text

Silverman (2017, p. 145) was critical of how interviews are conducted by researchers and argued: “ultimately, everything depends on the quality of the data analysis”. I have used the term ‘experiences’ throughout this study, and my research question aims to understand the ‘experiences’ of social care workers in diverse settings. However, I was very cognisant of Silverman’s (2017, p. 144) warning that eliciting “experiences and perceptions” ... “is deeply problematic”. Rather than analysing the text with the assumption that experiences are a ‘resource’, (Glassner and Loughlin, 1987), Silverman (2000, p. 151) suggests viewing experiences as a ‘topic’. He suggested the following transcription rules will help with this process;

1. “ Always try to identify sequences of related talk” Silverman, 2000, p. 151).
2. “Try to examine how speakers take on certain roles or identities through their talk” (ibid).
3. “Look for particular outcomes in the talk, (requests, repairs...) and work backwards to trace the trajectory” (ibid).
4. Don’t try to “make sense of a single line of transcript or utterance in isolation from the surrounding talk” (ibid).
5. Look for the normal in the dialogue, ignore what you know about the interviewees (Potter and Hepburn, 2012).
6. Look for what ‘function’ their comments may serve (Silverman, 2017, p. 154).

In qualitative interviews “people are asked about what they do and what they think, and they helpfully tell you about these things”, but in asking these questions, we are treating participants as if they had an exceptional analysis of their own behaviour and relationships (Potter and Hepburn, 2012, p. 567). Using Silverman’s guidelines, I analysed the ‘experiences’ of workers in diverse settings by listening for the identities they spoke through, (for example; professional, question answerer, victim) and the symbols and regimes of competence (Wenger, 1998) they elude to when describing their practice. As Silverman (2017, p. 148) contends “Meaning is mediated through language” and the interview is a two-way process, where meanings emerge through the relationship of the question and answer dialogue between the interviewer and the interviewee (Potter and Hepburn, 2012). Based on these recommendations the interviews were transcribed with all the ‘response tokens’ and pauses, and the ‘experiences’ of social care were analysed as topics; noting behaviours, actions and identity from the full transcripts.

4.6.5 Analysing Spoken and Visual Text: Personal Stories and Photographs

There are three types of narrative text used in research; spoken text (biographical life stories and stories about practice); written text (poems and journals) and visual text

(photographs, artwork, postcards) (Keats, 2009). In this study, both spoken and visual texts were collected. Workers shared their personal life story and selected specific practice stories to share in the interview. There is an awareness of the role of personal biographical stories in research (Kaplan, 2014), and that “to understand oneself and others, we need to understand our own histories and how we have become who we are” (Chamberlayne, Bornat and Wengraf, 2000, p. 7). Although life stories are subjective, “they still contain objective information” (Kaplan, 2014, p.48). There are many ways to analyse stories within research including 1) holistic-content - looking at the complete story, 2) holistic-form – looking at the structure of the story, the characters, the plot, 3) categorical-content – sections of the story are selected, and 4) categorical-form – look at the language used (Keats, 2009). Using these forms of analysis, the biographical stories of the workers’ journey in care can provide signposts to the historical and cultural influences on life choices and actions. Table 4.6 provides an example of the analysis process conducted on Sarah’s journey into care.

Sarah: Personal Journey Into Care	
Transcribed text	Narrative Analysis
“I forgot to apply for psychology”.	-First statement, was laughing when she said it. -Gives the impression that her decision was based on a random act.
“I don’t know, my mother used to make meals for retired nuns, and we always had a lodger. We always had a family member; we never slept in our own beds, it was luxury. We did because we were always being dispossessed of something”.	-Personal experience of being a witness to the care of others by her Mother (mother cared for others in work, kept lodgers, family members stayed). -Interested in use of term dispossessed, did she feel deprived of her possessions, her bed? Was money an issue at home? -Home environment promotes the care for others as a value system.
“Either the neighbours had been drinking and beating each other up, or the kids needed to stay in the house, or something was going on”.	-Witnessed violence and alcoholism at a young age. -Her home was a respite service for people in need.
“So I didn’t actually think about it, in college I wanted to do psychology”.	-Has identified with a caring and counselling role.
“I wanted to do advertising because I thought I was so witty and I had a fight with my English teacher because I wanted to do honours English, she was right I was wrong, I failed it. I forgot to apply for psychology, so I got offered nutrition and diet or something like that and was contemplating that and then social care was offered as a first round offer so I took that, and then I went into it, and I was like this is deadly I love it”.	-Identifies with having a sense of humour. -Forgetting to apply for psychology, reoccurring theme. Is she regretful, why did she forget? Did she lose her confidence over the English exam? She had applied for social care, and was offered a place on the first round offers, but did not phrase it in that way. Again it is presented as a random chance or happenstance.

Table 4.6 Narrative Analysis of Sarah’s Personal Journey into Care

Harper (2002) argues that the images produced in researcher-led photo elicitation process can be analysed in terms of what symbols the interviewee presents. Also, the meaning the participants attribute to the metaphors and symbols is central to the

analysis. Table 4.7 is a sample of the analysis process from case cluster three and exemplifies the method.

Case Cluster Three: Children's Residential Services		
<i>Participant Symbol</i>	<i>Participants' Explanation of the Symbol</i>	<i>Co-created Analysis</i>
Sarah - A cactus.	Whenever I have worked somewhere where people haven't been cohesive, I bring a cactus into the room. So, I have cactus in my staff meeting rooms because it takes negativity and this is what I tell people so they believe the cactus takes negativity and then we can all have very open conversations about the needs without anyone getting insulted or upset or whatever.	Reducing negativity in staff teams, promoting open communication.
Emma - Photos of children and their families - Drawings on the fridge	I suppose I would talk about life story and photographs. Photographs from clients that were there 10 years ago, all collages. Photos are memories for them; I think a lot of children coming out of care have very bad memories. One client has pictures of her family, her dad, she makes it [the space] hers. Drawings made on family visits are put on the fridge. I did their handprints going up the stairs.	Objects of home, ownership, capturing positive experiences as memories

Table 4.7 Case Cluster Three – Themes from the Research-led Photo Elicitation

The chapter concludes with the final stage of analysis where the transcribed text and imagined stories of practice were translated into drawings for further analysis and discussion.

4.6.6 Visual Reading

“It is seeing which establishes our place in the surrounding world, we explain that place with words, but words can never undo...this always-present gap between words and seeing” (Berger, 1972, p. 7).

The *reading* process of interpreting the primary data, was, in reality, a combination of both ‘reading’ and ‘seeing’. As previously discussed, art is a comfortable medium for me, and I understand the world around me through a combination of words and images. Visual reading in this thesis is the use of drawing for analysis. The term ‘visual reading’ was suggested by my supervisor Dr Karl Kitching to name this process of analysing data (interviews and transcribed text) through the use of images. Interestingly, the term was used in a much earlier article by W. B. Secor entitled *Visual Reading: A Study in Mental Imagery* (Secor, 1900). The article described a psychological test to examine if ‘words’ are seen in the mind before they are read in printed form. ‘Visual reading’ is also a commonly used term in visual literacy (Serafini, 2014) in the context of reading images, or used to describe the span of vision used in speed reading (Konstant, 2000). Keats (2009, p. 190) also used the term visual reading as a way of analysing images, where photographs or images are ‘read’ for ‘visual signifiers’, for example; content, the position of objects and use of colour. In this study, the term visual reading is used to represent a process which results from a translation of words and text into images in my mind, which are then interpreted and presented as a drawing. I have described the process involved in visual reading as including three stages; creative interpretation, visualising the new and expressing the inside out, illustrated in Figure 4.4.

Creative Interpretation: Visual reading enables researchers in the process of interpreting non-textual information (images, photographs, video, art based mediums,

dance) related to their phenomenon of investigation, to demonstrate their analysis in a medium complementary to the visual data under review. Depending on the researcher, visual reading may be actualised in a variety of visual mediums. Central to this is *balance* from the *reading* and *seeing* of the phenomena to an external projection or presentation of what has been made one's own in a format that requires both *reading* and *seeing* from a future audience. The researcher must also possess knowledge and expertise in his/her chosen medium to use this process, which aims to aid the comprehension of the data.

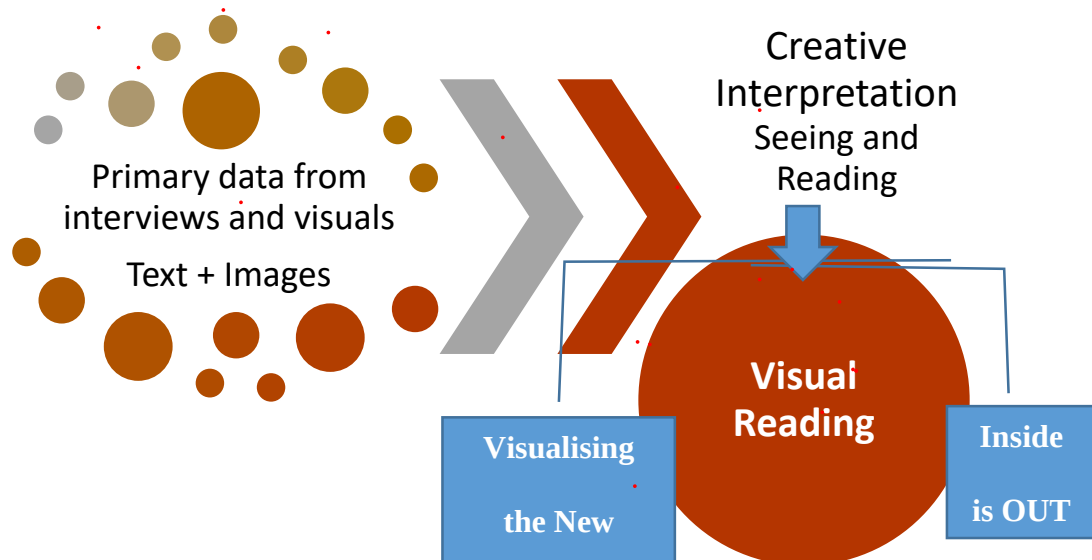


Figure 4.4 The Process of Visual Reading

Visualising the 'New': Essential to visual reading is a representation of the new knowledge from the analysis of the textual and visual data. This requires an increased focus towards objectively presenting the analysis, to stand in front of the 'work' (Kindler, 2007). This will create a tension between the researcher/artist's subjective self (past image making) and this visual interpretation of what is made one's own. As

“art can express emotions, ideas, desires and complex thoughts” (Frith, Riley, Archer and Gleeson, 2005, p. 191) subconsciously, the process of clarifying the new interpretations enhances the process of analysis. Thus, the researcher is compelled to reflect upon and re-examine his/her interpretations of the ‘work’.

Expressing the Inside Out: As with all research, the published thoughts and ideas are open to the interpretations by the *reader*; the image is also accessible to the multitude of possible interpretations by the *see-er*. Images are a “source of knowledge construction in their own right” (Frith, Riley, Archer and Gleeson, 2005, p. 187). Within research, the ‘risk’ of opening yourself up to the interpretations of others normally lies within the realm of the participant, as they share their lived experiences. Here, the researcher sits protected from judgement of self by others, through being distanced from the presentation of the findings. Yes, the researcher is the author of the ‘analysis’ and the collective ‘voice’ of others, and thus may be critically judged on their methodological and academic ability, but the risk is not equitable. Visual reading demands the researcher express another layer of interpretation, what they see and understand. This practice bonds the researcher to the research process, a visual expression of the co-created meaning of the case being explained, and to the vulnerability of self now shared by both the participant and the researcher. The researcher can empathise with the vulnerability of the participant and the level of trust needed for them to share his/her self with the researcher. Visual reading also heightens the researcher’s awareness of the privileged position they hold and how important it is to protect the participants’ voice, story and maintain his/her anonymity. Figure 4.5 is a visual reading of a theme that emerged from analysis and re-reading of the data, which I coded as ‘pushing back’.



Figure 4.5 Visual Reading - ‘Pushing Back’ (Source: Drawing by Denise Lyons)

The drawing depicts the worker pushing a ‘Sisyphus’ type stone up the stairs (hill). The analysis of this visual reading (located in Chapter Five) is linked to the statements from workers about resisting and pushing back against managerialism and the negative effect some austerity measures have had on the service users. It also reflects a pushing back against the workers’ reliance on allied professions in practice. As I read the text, the theme resistance and ‘pushing back’ began to become imagined in my mind and I saw a female worker pushing a large yoga ball up the stairs of a

residential centre. Using the visual arts in this way promotes the emergence of multiple realities from ‘seeing’ the image (Eisner, 2008; Leavy, 2015).

4.7 Conclusion

Paradigmatically, my thesis question takes a constructivist perspective where the multiple socially constructed realities of social care practice are determined by the claims of those working in diverse practice settings. The methodological approach deemed most appropriate to ‘bring to light’ the practice of social care is holistic multiple case study research (Yin, 2016). This choice stems from a desire to ask social care workers *how* they experience practice in a specific setting (Stake, 1995, 2006). Purposive sampling aided the selection of twenty-six social care workers from multiple settings (Maxwell, 2013). For the purposes of analysing workers’ contexts and practices in Chapters Six and Seven, these settings were grouped into three case clusters based on their relationship to their originating ideology of the deserving and undeserving poor and the medical model of care. The qualified workers in these three clusters are from; homeless services, mental health, residential child care, disability day care and disability residential care. Adhering to ethical procedures, the qualified social care workers agreed to participate in a semi-structured focused interview.

Research-led photo elicitation brought forth the imagined spaces (Holland et al., 1998) or metaphors of practice. Data analysis of these visual spaces was aided through the use of drawings, defined as ‘visual readings’, which enabled me, the artist and visual learner, to illustrate my analysis and interpretations of the workers lived experience. Creative methodology supports the reflection on, and elaboration of, the

workers' experience of situated practice. Now that the methodological strategy of case study research is established, ethical considerations outlined, thematic analysis explained, and the qualitative software tool presented, the next stage in the research process is to present the findings and data analysis from the methods used. Thematic analysis (Braun and Clarke, 2006) was selected as the interpretative framework for the visual and textual data collected from the focused interviews (Yin, 2009) and arts-based methodologies (Rose, 2016). The qualitative software tool NVivo was used to assist the analysis of both text and images, which is presented in the following findings and data analysis chapters; identity in Chapter Five, practice in Chapter Six and context in Chapter Seven.

Chapter Five Social Care Workers Ordering of the Claimed and Performed Identities of Self

5.1 Introduction

Although this thesis has structured the three themes in the order of practice, identity and context, it was essential to begin the data analysis with an introduction to the workers, who are the centre of this story. Twenty-six workers thinking and talking about ‘what is social care’, provided an insight into the multiplicity of their experience of practice and how power relations have ordered and subjected their self and their understanding of practice. Is a timely and very valuable exercise in the wake of the registration process, and the gathering of relevant discourses which will ultimately shape social care into a profession or discipline of sorts (Hutchinson, 2017). This first findings and data analysis chapter provides an introduction to, and identity-based analysis of, the participants of this study, 26 social care workers. The chapter begins with a summary note, explaining how the three findings chapters are viewed through the integrated lens of sociopolitical theory, social pedagogy and situated learning. This chapter continues by describing the workers’ own journey into care, including what influenced each worker towards a career in social care.

The workers belong to predominantly female teams, and the discussion on gender in practice is followed by an insight into the influence of training on the workers’ identity. Workers described their practice experience as a transition, a rite of passage to claim the identity of a social care worker. This chapter also outlines the identities claimed by workers within practice and how performing as a worker during training was a successful way to gain employment. Overall, this analysis does not aim

to present one truth of social care, but how many voices contribute and add value to the existing systems and representations of social care.

5.2 Identity, Practice and Context Viewed through an Integrated Lens

As the key question ‘what is social care’ suggests, the overarching purpose of this holistic multiple case study was to understand what social care is, from the workers’ perspective. The concept of ‘social care work’ is widely discussed and defined (IASCE, 2005; Lyons, 2007; Lalor and Share, 2009; 2013; Graham, 2011; Finnerty, 2013; Byrne-Lancaster, 2013), yet, as Chapter Two discussed, it is still contested (Hutchinson, 2017). Evident from the responses provided, social care is “a hard thing to define” (Eddie, children’s residential care). “The whole social care thing is so difficult; it's just that nobody understands it, you know in my experience of it” (Samantha, CAMHS). To understand the workers’ identity, practice and their contexts of care from the responses provided, the integrated lens of sociopolitical theory⁶⁸, Wenger’s (1998) regimes of competence, Turner’s (1969) liminal situations, in conjunction with the social pedagogical triptych of head, hands and heart was used (Foucault, 1977/1995; Lave and Wenger, 1991; Petrie et al., 2006; Digney and Smart, 2014). The aim here was not to identify each social care service as a potential ‘community of practice’ *per se*, but to utilise the integrated framework of Wenger (1998) and the social pedagogical ‘trinity’ (Cameron and Moss, 2011) to support the discussion on defining social care practice within each setting. Also, the purpose of

⁶⁸ Sociopolitical theory takes into account the view that the language the workers use is not neutral, it is both political and social, which can make history and create change as well as recall it (Foucault, 1977/1995).

this discussion was not to categorise practice as limited to this integrated framework, but to assess the significance of this frame as a guide to greater understanding. The chapter begins with an introduction to the 26 participants, defined by their pseudonym, their practice setting and the title they are given there by the employer in Table 5.1.

5.3 The Journey into Social Care Practice

M/F	Name	Service	Current Job Title
F	Paula	Residential care for children with ID	Social Care Worker
F	Una	Residential children with sensory disability	Social Care Leader
F	Mary	Children's residential care	Social Care Worker
M	Adam	Residential care for unaccompanied minors	Social Care Worker
F	Sarah	Children's residential service	Regional Manager
M	Eddie	Children's residential service	Social Care Manager
F	Emma	Children's residential service	Social Care Manager
F	Alice	Day activation for adults with id	Senior Supervisor
F	Kate	Day service for acquired brain injury	Facilitator
F	Laura	Day service adults with ID and physical D	Social Care Worker
M	Liam	Outreach in disability service	Outreach Coordinator
M	Simon	Residential for adults with ID	Social Care Leader
F	Rita	Residential for adults with ID	Social Care Leader
F	Olivia	Residential for adults with autism	Social Care Worker
F	Ava	Residential for adults with ID	Social Care Leader
M	Jim	Homeless residential service	Social Care Worker
M	Colm	Homeless residential service	Social Care Manager
M	Frank	Homeless service aftercare team	Aftercare Worker
F	Bernie	Homeless residential service	Project Worker
F	Clare	Homeless residential service	Project Worker
F	Michelle	CAMHS	Social Care Leader
F	Samantha	CAMHS	Social Care Worker
F	Joanie	Addiction residential service	Project Worker /Manager
F	Sheila	Addiction residential service	Case Worker
F	Joan	Youth crime prevention project	Project Coordinator
F	Amanda	In-house training for SCWS	Training Officer

Table 5.1 Research Participants: 26 Social Care Workers

This chapter begins with a description of becoming a social care worker, experienced as a transition, a rite of passage (Turner, 1969), moving from the novice to the status of a competent social care worker, by spending time in practice with others and gaining experience on the floor.

5.3.1 Becoming Competent: “Identity Comes from Experience”

All of the participants in this study were in practice for at least five years, and the following four workers had over twenty years’ experience;

- Amanda worked in children’s residential care during the time when care was provided in large group homes managed by Religious Orders.
- Ava started in disability services, worked in children’s residential and returned to adult disability services.
- Mary has worked in children’s residential care and is now in management.
- Sarah began in children’s residential care and is now also in management.

Overwhelmingly, the responses linked identity to experience, summarised in Joan’s statement; “in this line of work identity comes from experience” (Joan, Youth Crime Prevention). There was evidence from the discussion that time was necessary for workers to progress from the identity of newcomer to become the competent old-timer worker (Lave and Wenger, 1991). This is experienced as a transition from the status of novice, the naïve worker who develops into a competent worker, through time spent engaging with others (Thomassen, 2014). Workers reminisced on their young selves as being naïve and overwhelmed by what they initially experienced. “It was difficult, in a lot of ways it was an eye opener for me” (Samantha, Mental Health). Years of experience enabled workers to feel more comfortable and confident in their acquired skills and knowledge, and within the relationships they had developed with the service

users and the team. Workers described these ‘years of experience’ as a rite of passage (Turner, 1969), through which social care practice ‘is learned’, and the social care worker identity claimed (Lave, 1991; Schachter, 2015). Joanie described her initial experience of entering an addiction service through the following statement; “When I first came to work here, and I was looking around the place, and I was completely overwhelmed. I couldn't understand what they were all talking about, what is this language”. As well as the experiencing the newness and strangeness of the experience, Joanie was aware that there was a language indigenous to the setting that she was also unfamiliar with (Wenger, 1998). After the transition, when experience is gained, and language learned, the more confident and “more determined” (Adam, Children’s Residential Care) workers were able to be more present “because I have the years of experience behind me I am comfortable asking questions, I am comfortable kind of sitting with it” (Samantha, Mental Health). Samantha’s ability to sit with her practice is evidence of her understanding of the importance of being and presence in her work (Garfat and Fulcher, 2011; Digney and Smart, 2014).

Gaining all this experience takes time, but there is a downside to years on the floor, being physically and emotionally able for social care work as an older worker. Workers also stated that certain aspects of the work including shift work, waking nights, and dealing with behaviours that challenge were more difficult to endure for the older worker especially if they had a family of their own, or have already reared them (HSA, 2012; Steckley, 2014; Ferri et al., 2016).

“The unnatural bit for me I suppose is that you have your children, you raise them, and then you become a grandparent, maybe, and as a grandparent, you have a very different relationship, and you don’t have them all the time. But for residential workers, they are there at the age where they might be

grandparents, and they are thinking this is too hard, this too much, the emotional impact or the stress of it” (Amanda).

Although age brought experience and the ability to be reflective and aware (Fewster, 2013), there was also an openness to the challenges of doing social care when you are older, which is an under-researched area. As social care is a predominantly female profession, it was important to consider gender as relevant to the workers’ experience of practice and the development of their identity as a social care worker.

5.3.2 Influence of Gender

Seven of the participants in the study are male, and nineteen interviewees are female, which is representative of social care as a predominantly female profession (Lalor and Share, 2013). This male to female ratio in social care is a remnant of the ‘cult of domesticity’ and the role of women being the primary carer of the family (Cott, 1977; Fisher and Tronto, 1990). Gender balance in social care was raised by the participants as a desire, rather than a reality. All workers stated that their team was predominantly female, with the exception of one team which had an equal number of males and female workers. This was experienced as unique, and Olivia (Residential for Adults with Autism) argued that “because it's autism there are a lot of male service users”, which necessitated the need for an increase in male staff. Liam (disability) argued that men are frequently used to deal with the more physically challenging situations “a little bit more than females”. Olivia also noted the difficulties experienced by the male staff on her team, especially when performing the role of personal or intimate care with female service users “one of the ladies said flat out she doesn’t want males doing any personal care of any description”.

The only negative comment towards men in social care was expressed by Sarah (children's residential care), who believed that male workers were promoted to management more quickly than their female colleagues. O'Toole (2013) argues we need more analysis of the opportunities afforded to men over women in social care, for example in Colm's case, who is the manager of a homeless service, and the only male staff in the unit. Sarah also stated that female workers "don't really care who [which gender] is above them, because their fulfilment from the job comes from the doing". The implication here was that Sarah believed that male social care workers are more ambitious than females. Smith (2009) argues that men and women demonstrate care in different ways and the children should experience both.

Social care practice needs to get away from the binary views of gender in social care, and the male versus female debate (Smith et al., 2013). "It's like male/female; I don't care if they can do the job and that's it. It's good to have a balance on the team, but they are not out there, the ones that meet the targets are the females at the moment in relation to the interviews" (Colm). Colm's statement that the female applicants 'meet the targets' was not elaborated upon. However, there is evidence, although limited, that the missing male voice in care is indirectly maintaining social care as a feminine profession. The discussion continues with the personal journey into social care of this predominantly female and mature cohort, who also 'met the target' at their interview and entered the social care workforce.

5.3.3 Personal Journey into Care

The worker's journey into care outlines how their own personal experiences, attributes and characteristics, or own experience of the care system influenced them towards this career. The stories of the workers' journey into care identified the three main motivational factors which influenced the workers towards a career in social care; wanting to help or support others, having an early personal experience of receiving or witnessing care and being described as caring by an influential adult (Illustrated in Table 5.2). Figure 5.1 is an illustration to reflect how the idea of becoming a social care worker was planted during the formative years of many of the participants in this study. Either they witnessed a family member or neighbour being caring to another person, or they were told by an important and influential adult that they had the personality traits suitable for social care work.

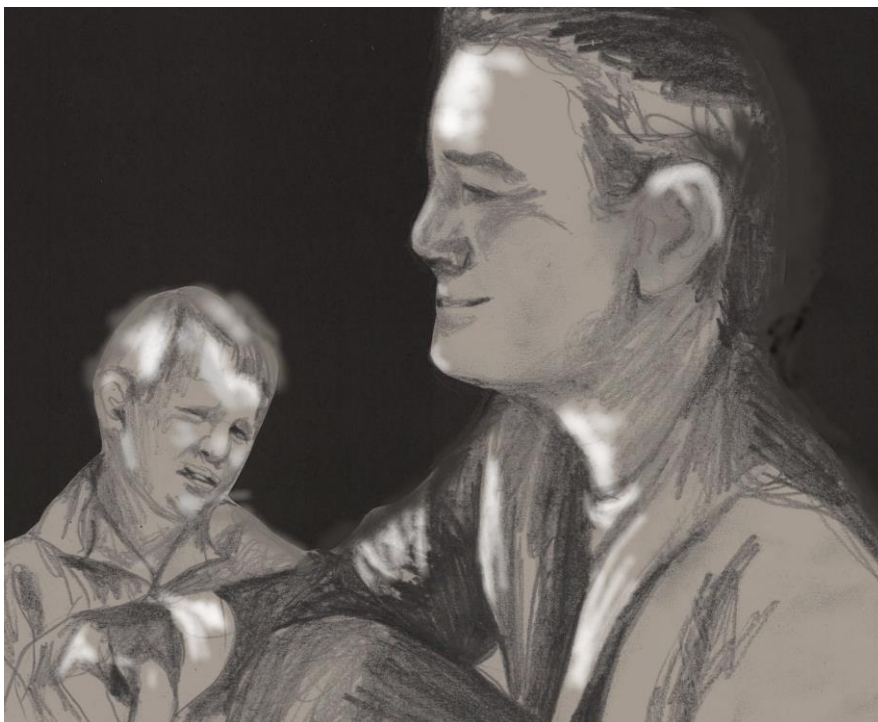


Figure 5.1 'I want to be like you when I grow up' (Multimedia by Denise Lyons)

Motivated to Help	Personal Experience
<p>R. Mary – “Wanted to work with people”.</p> <p>R. Sarah – “Always people needing help came to my home”.</p> <p>H. Joan – “Wanted to help people”.</p> <p>H. Sheila – “Wanted to help people”.</p> <p>H. Jim – “Always interested in people”.</p> <p>M. Michelle - “Wanted to be a nurse” and was interested in helping people.</p> <p>H. Colm – “Interested in people” and did some volunteering as a kid.</p> <p>H. Frank – Enjoyed transition placement and “working with people”.</p> <p>D. Paula – “Wanted to be a nurse “and help people.</p> <p>D. Kate – “Volunteering got me interested in focusing on people”.</p> <p>D. Rita – “Interested in people with a disability, I never worked for any other organisation”.</p> <p>R. Amanda – “I always worked with kids and the scouts”.</p>	<p>R. Emma – “Neighbour was a foster parent, and I used to babysit for her”.</p> <p>H. Joanie – “My friend died from heroin addiction”.</p> <p>D. Alice – “My sister has a disability, so I have grown up with an interest in people”.</p> <p>D. Simon – “Mum is a social care worker”.</p> <p>D. Laura – “I had a couple of family members with physical disabilities so I had always been caring for them from a very young age”.</p> <p>H. Jim – “personal experience of addiction and mental health”.</p>
Innate Personality Traits	Not First Choice
<p>H. Bernie – “I was always the kind of go-to person”.</p> <p>D. Una – “From when I was younger people always came to me for advice”.</p> <p>D. Liam – “I was always good at talking to people”.</p> <p>D. Ava – “In school, I would have been the one that stood up for the picked on person”.</p>	<p>H. Clare – “Came the long way into social care as a way of doing something different”.</p> <p>R. Eddie – “Just fell into it”.</p> <p>R. Adam – “Just fell into it really”.</p> <p>D. Olivia – “Philosophy was my first choice, so I hadn’t given it much consideration when I picked social care”.</p> <p>M. Samantha – “By accident, my first choice was teaching”.</p>

Table 5.2 Personal Motivation to Enter Social Care

Table 5.2 provides a summary of the participants' motivations to become a social care worker. The table is structured under the following headings;

- *Motivated to Help*. This section includes all the responses that mentioned wanting to help or support others from an early age.
- *Personal Experiences*. This category includes all the comments made about having an early experience of care or witnessing the care of others by family members or neighbours.
- *Innate Personality Traits*. Identity claims as a helper or being told you are good with people and have suitable personality traits for care work.
- *Not First Choice*. This is a generic category to capture the statements from participants who ended up in social care due to various choices and experiences.

The data analysis continues with the main motivator to become a social care worker; wanting to help and support others.

5.3.3.1 Motivated to Help

As Table 5.2 illustrates, twelve participants in this study (almost 50%) wanted to help people from a young age, and a further four claimed their caring characteristics motivated them to help others. Many of the workers in this study wanted to help people because they were told at a young age that they had caring qualities and were good with people. People create a sense of their own identity from the influences of the force relations in their formative years of life, first, by becoming particular kinds of subjects (Foucault, 1977/1995). Their identification with being a helper (Jenkins, 2014) is integral to their sense of purpose (Lynch, 2009) and is reflected in their motivation to help others as a career (Behan, 2014; Ormond, 2014; Walsh, 2014).

Within the stories explaining why they wanted to help people, there is evidence of a significant other, a person/persons who acknowledged the caring characteristics in them, and may have suggested or openly encouraged the interviewee towards social

care (Kaplan, 2014). These protagonists appear to have helped the worker to acknowledge their own ‘helping tendencies’, and/or to see they were suitable for social care. The participants described these intrinsic qualities as; being a good listener, good with people, and being warm. These personal characteristics were frequently, and comfortably ‘owned’ during the interviews (Jenkins, 2014). Most participants had identified with caring from a young age in a deep rooted way (Byrne, 2009) and five wanted to emulate the behaviour of influential adults in their life, specifically their Mum or Neighbour. Their identity formed from watching these adults caring for a family member with a disability, or being caring towards the foster children in the home. Their experiences were mirrored in the personal journey of Paul (2014) who was also motivated to become a social care worker based on her early experiences of caring for her sister.

Located within research with child and youth care students, Ricks (1993, p. 19) asserts that 49% of her students had “three or more systems of dysfunction in their lives” in common with social care service users, and this personal experience can also influence people towards working in social care. If this statistic was applicable to graduates of social care programmes in Ireland, then at least twelve of this study’s participants would have some experiences similar to those of the people in their care. Interestingly, only one of the participants (Jim, homeless services) shared an experience of being on the receiving end of care. Archer (1980) and Spears and Lea (1994) argue that people will not self-disclose about negative experiences in interviews when they can be seen by the interviewer, one of the disadvantages in using a face-to-face interview as a methodological tool (Opdenakker, 2006). It was apparent in the interview that Jim’s ease and acceptance of his own story enabled him to extend

this accepting and non-judgemental attitude to others, from a place of kindness. Foucault (1977/1995) highlighted how society, institutions and families discipline and subjugate ‘subjects’ through ideas of normality. One of the most influential institutions acting as an ordering space for the subjection of the research participants was the Irish second and third level education system.

5.3.4 Academic Journey into Social Care

Sixteen participants made statements about leaving school early, or lacking in academic ability, or not having the points for college, or that the career guidance teacher felt they were not bright enough for social work or nursing. Many workers based this lack of confidence in their academic ability on their early experiences of secondary school. Only six participants chose to study social care as their first choice leaving school. Two of the six participants who chose social care as their first career choice defined themselves as academically poor, and entered the college programme through a Post Leaving Certificate PLC⁶⁹ course. Eight participants stated that they did not get their first choice of career (social work, teaching and nursing), and blamed poor academic ability, high points and limited interview skills. Although these participants described their journey as random, or by default, and that they ‘fell in’ to social care, all stated that they were glad they ended up there. For example, Paula had applied to a course on the medical side of caring; “I wanted to do nursing. I always kind of wanted to do nursing, but I love the area I’m working in. I work with disability”. Interesting, the three workers who did not get their first choice of nursing

⁶⁹ PLC refers to Post Leaving Certificate Programmes which educate students for QQI levels 3-6.

(Paula, Liam and Simon) now work in disability services, the most medically aligned of the social care sectors. Table 5.3, illustrates the workers' academic journey into social care.

Journey into Social Care	Dis	Home	Res	Total
Straight from school as the first choice	2	3	1	6
Another career before social care	2	4	3	9
Didn't get the points for nursing	3			3
Didn't get the points for social work	1			1
Didn't get the points for teaching	1		1	2
Didn't get the points for philosophy	1			1
Entered through PLC	2		1	3
Early school leaver		1		1
Total	12	8	6	26

Table 5.3 Academic Journey

It may not be evident from Table 5.3, but twenty-one workers studied social care as full-time students. Six were offered their first choice, seven by default, three through the PLC system (see footnote 76) route and there was one early school leaver, who went back to education. In Table 5.3, nine participants are listed as having another career before social care. Four of these nine went back to college full-time as mature students. The remaining five were already employed in the sector and studied social care part-time on day release from their posts as social care workers. Amanda's comment demonstrates how her professional identity changed after she started on the social care programme.

“We didn't see ourselves as professionals because this was what we wanted to do, but when we started going to college and thinking about what we knew we realised we had to professionalise ourselves, to be treated with more respect from other professionals. Before Amanda received her education, she felt that “when decisions were made at meetings, our opinions didn't count and we were the people living with the kids, who knew them so well on day to day basis” (Amanda).

In relation to the workers' experiences in college, the participants were asked about the role their third level social care education played in the development of their identity as a social care worker and the practice training they received.

5.3.4.1 Identity from Social Care Education

The participants were asked if they identified themselves as a social care worker based on their college experience. Participants who felt they had formed a professional identity as a social care worker, while in education, were older when they returned to education either as a full-time or part-time student. Through the college system lecturers are “constituting on them (i.e., the student) a body of knowledge that is accumulated and centralised” (Foucault, 1977/1995, p. 231, my parentheses) within their own academic discipline. In most cases, the lecturing ‘experts’ did not come from the discipline of social care, as this was a new programme the lecturing staff consisted of an eclectic team from the disciplines of sociology, social work, psychology and social policy (Share and Lalor, 2009; Lalor and Share, 2013). The educational background and professional discipline of individual lecturers teaching social care had an impact on the developing identity of the social care worker in training, which is reflected in the findings.

The workers attributed developing a strong understanding of their professional identity from having lecturers trained in social care and from the outside speakers, who spoke about their practice ‘on the floor’. The participants judged the outside speakers from the profession of social care as having an understanding of practice that resonated with the student’s own experience, and were “telling the truth about oneself”

(Jim). “There was also a sense of aspiring to be part of the change, and these experienced workers were flying the flag” (Sarah). This preference for an expert from the profession of social care was not an example of anti-intellectualism, rather the participants’ acknowledgement that lecturers, or outside speakers, educated within the discipline of social care understand the lived experience of practice. Three respondents also mentioned having lecturers who were qualified social care workers and added that they understood and promoted the profession. Within the classroom, these were the only two contributing factors to the workers’ sense of identity as a social care worker: having a practice lecturer as part of the team, and/ inviting social care workers to come in and talk about their practice. Despite the lecturer’s best efforts, placement was described as the main learning environment for social care practice and the space where workers developed a strong sense of identity.

5.3.4.2 Learning on Placement

“We did two day’s placement and three full day’s college for the three years, doing a different placement each year. Working in a placement for an entire year while studying really allowed me to become part of the service and to get involved in the work” (Bernie, homeless service).

Evident from Bernie’s statement, placement enabled her to feel part of a team, as belonging to the organisation and the profession through being engaged in the situated learning of practice (Lave and Wenger, 1991). The placement was presented as a positive experience by most of the participants and defined as the home of their situated learning (Lave, 1991). The participants’ experience of placement was varied, which reflected the literature arguing the quality of the placement experience depends on the college structure and on the availability of qualified social care supervisors

(Mulkeen and Gilmore, 2009; Lancaster, 2014). Being supervised by a social care worker was identified by the participants as a significant factor in the formation of their identity as a social care worker before leaving college, which reflects Lancaster's findings (2014).

The participants also talked about the role of placements as a potential employer, where the student was showing their ability to do the role, performing social care work, in the hope of gaining employment in the service, while occupying the role of a learner (Butler, 2005). Seven participants gained employment from their placement. Alice stated "I went on placement in my second year into an intellectual disability area and I just happen to still be there" while Liam said "I really loved working in that placement, I got a wee job from it as well, a couple of residential shifts thereafter and worked there for a couple of years after that". Placements also provided opportunities for social care workers to gain employment in 'new sectors', other than the traditional settings of children's residential care and disability services. Joanie related that she only got her job in an addiction service "because I did my student placement here and they got to know me, at that point, there was no social care workers here at all".

Evident from the discussion, many participants were already working in social care before they officially left college. Several workers were critical of their overall social care education, stating that it did not adequately prepare them to work in their specific sector. Eight participants have further qualifications outside of a postgraduate qualification in social care. The two CAMHS workers have additional training in Cognitive Behavioural Therapy (CBT). Two workers from the homeless sector have an MA in Criminology, Colm has an additional degree in Addiction Studies and Frank

an MA in Management. Two workers from addiction services also have achieved post-graduate qualifications in addiction. All respondents stated that their professional identity as a social care worker strengthened once they started working as a social care worker, apart from two in adolescent mental health. One CAMHS worker declared that in her current role she felt she has ‘left social care’ (Samantha) to do more therapeutic work with clients. The chapter continues with an exploration of the development of the workers’ identity within the specific service they are currently employed in.

5.4 What do they call you here?

“I called myself a social care worker before I was a social care worker because someone told me that's what I was” (Jim, homeless services).

The title of ‘social care worker’ was socially constructed in the mid-1990s to reflect the needs of the care industry, and the expansion of education programmes of ‘child care workers’ to include workers within other care settings (Courtney, 2012; Lalor and Share, 2013). Social care work originated within two main disciplines; children’s residential care (Clear, 1987; Raftery and O’Sullivan, 1999) and the disability sector. Several of the participants remembered when their title was “assistant house parents and house parents” (Simon, disability), and when workers were mostly untrained (O’Mahony, 2002; Gilligan, 2009; McHugh and Meenan, 2013). The slow adoption of the title ‘social care worker’ by society, individual care settings and the workers themselves was evident within both Sarah’s and Ava’s comments:

“I suppose in the old days you had to justify the title almost, you had to say to people no that’s not what we do, we are not social workers, no that’s not what

we do we are not SNA⁷⁰s. You know. you had to justify what it was you did, and people didn't generally know the job" (Sarah, children's residential care).

"I think when we were called care workers maybe that was what was confusing people; they would all ask if I work in a crèche" (Ava, disability).

Although all participants self-identified as a 'social care worker' when they answered the invitation to participate in this study, they were defined by multiple titles in practice. The titles given to workers by their employers frames the discussion on their practice to others, as discourse is functional and effects change, the title becomes the label, part of their identity claim (Waterman, 2011; Schachter, 2015) and of how others will view them. Participants were defined in the following ways;

- **13 Social Care Workers**
- **3 Social Care Managers**
- **2 Project Worker**
- **2 Project Worker/Manager**
- **6 Individual Titles (Aftercare Worker, Supervisor, Outreach Coordinator, Facilitator, Case Worker, Training Officer)**

Several participants, although defined as a social care worker within their work setting, stated that they did not use the title when outside of work. "I don't think people outside social care have a clue what it is that you do, you are better off saying you are a plumber" (Eddie, children's residential care). This comment may be indicative of society's reaction to the ambiguity of social care, and also an indication to the worker's perception of social care having a low professional status. It is also interesting that Eddie chose a predominantly male profession as his pseudo occupation, which may be related to his perception that social care is viewed by the general public as women's

⁷⁰ SNA Special Needs Assistants.

work. This issue is discussed later, in the context of the hierarchies within helping professions and the greater valuing of the medical and scientific expert (Foucault, 1977/1995). The chapter continues with an exploration of what it is like to be a social care worker, based on the identities claimed and performed.

5.5 Being a Social Care Worker: Claimed Identities

Social care workers were asked to define what being a social care worker was like, for them. Mary stated;

“I found it a very, very difficult task to think about what would represent social care and social care practice. I found it very hard because it is what I have come to believe over my years, is that I own my own care practice and that it means it's intimately connected with who I am. When I started, I think I understood my employer ‘owned’ what I did, and I got sucked into that, and I think when practitioners work in teams and in groups, that is one of the things that we can risk. But increasingly I have come to own my own practice”.

Mary’s critical perspective of owning her own practice and the idea of her work being a part of her, and connected to how she is, was reflected to some degree in the social care worker’s responses, irrespective of the setting. Mary also noted the potential *risk* of losing her *own care practice* through the negotiation of decisions and practices with her other team members (Wenger, 1998). Also, Mary’s comment shows that she became aware of her own subjection, *getting sucked into* and having her practice influenced by external power forces (Foucault, 1977/1995), but this awareness enabled her to reclaim and re-own her practice.

The multiple roles of social care work are described as a defining characteristic of the experience of being a social care worker, and this was a common theme expressed by workers within all settings. The claimed identities (Gowland and

Thompson, 2013), demonstrated that social care workers are self-identifying with these claimed roles (Bogo, Raphael and Roberts, 1993; Evans, 2001; Grøn, 2004). The 'roles' identified changed, based on the defined needs of the service users and the setting (Lave, 1991), but the workers knew who they were based on these roles (Jenkins, 2014). Social care workers in the study claimed to be; change makers; helpers; key-workers; team members; whistle-blowers; advocates; organisers and observers.

The most common role/identity claimed by the participants in the study was 'to help and support others', although many workers did not feel completely comfortable with the term, viewing it as limited, "being a social care worker means much more" (Paula).

"Being a Social Care Worker is about making a change and difference in people's lives and allowing them to live as equal a life as others. It means that I am a small part in a larger process of helping someone discover who they are, what their skills, abilities are and how they can best achieve them" (Paula, disability service).

Physical and psychological safety was central to the helping process, where the participants were "helping to make people happy to be there and to feel safe" (Bernie, homeless), "first of all in the environment that they are in but also with me" (Sheila, addiction service). Both Samantha (CAMHS) and Joanie (addiction services) stressed the responsibility of being a helper and how it is both a privilege and a humbling experience to be in a position to help. "It means loads to me, it's a privilege, I actually feel a bit emotional saying that and it really still is. Being part of their journey and being part of that process is humbling" Joanie (addiction services).

The second most popular identity claimed was the ‘team member’, which included the activity of teamwork, and the reality of different personalities on the team’s dynamics. Emphasis was given to the importance of having a strong and supportive team based on trust and mutual respect and how a good team can embrace new team members and challenge their existing approaches. However, workers also highlighted how personality differences, a lack of humour, or a lack of cohesion could cause more work-related stress than direct care with the service users. “A great staff team is where everybody was really engaging with the clients, and there was a lot of kind banter” (Bernie, homeless sector). Three of the participants claimed the identity ‘whistle-blower’ and described experiences when they reported the poor treatment of service users and staff, although they described the experience of reporting as stressful they believed they “had done something right” (Jim, homeless service).

Another common identity claim was the ‘advocate’, and workers spoke of speaking up on behalf of others and representing their needs to other professionals and organisations. This identity claim was also present in the personal journey into care, where workers spoke of advocating for other children in school, or for other members of the staff team for better conditions. These statements were mirrored in the discussion on the identity of ‘key-worker’, especially in homeless, and addiction services and children’s residential care. This role was described as a one-to-one relationship; a space to catch-up and chat about things, “the one-to-one time is a fantastic environment for people to get a lot of learning and growth because you are going to be working with them from start to finish” (Joanie, addiction services). Emma (children’s residential care) described herself as an ‘organiser’; an identity also claimed by fellow residential workers Paula and Eddie, and Amanda. Being organised

was linked to the multiple roles and tasks involved in social care and the increase in form filling and paperwork. Finally, being an ‘observer’ was presented as a social care identity, to reflect the need to constantly check-in and observe and record the actions of others. Social care workers rely on their interest in people, “in picking apart” (Clare, homeless service), in learning how they think and why they act in certain ways, and “why are they at a place in their lives” (Bernie, homeless service).

“It’s a bit of everything” (Ava, disability). “A bit of a kind of a friend, a kind of a family member, you are a teacher, you’re a brother, you know we all play different roles with them at different stages, depending on who your clients are” (Sarah, children’s residential care).

Figure 5.2 is a Visual Reading inspired by the multiple identities claimed by workers. In Figure 5.2 the worker is depicted as a unique jigsaw made up of individual pieces that come together to form the whole self of the worker. The individual jigsaw pieces represent the multiple identities claimed and performed. There are also pieces missing to reflect the worker in transition, the private self, the pieces that did not fit within the bigger picture, which together captures the humanness within these unique workers.

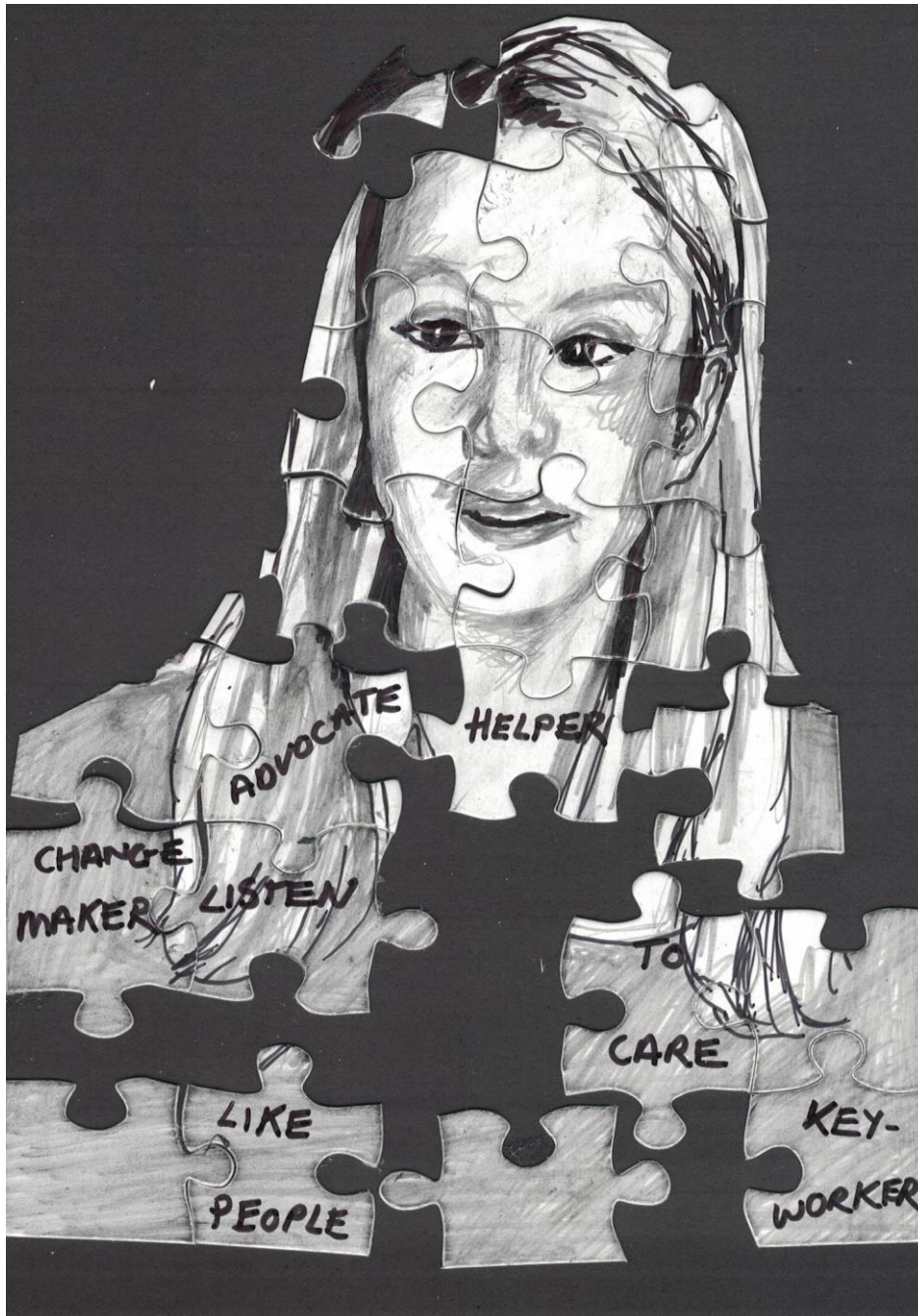


Figure 5.2 Visual Reading: The Multiple Selves Claimed (Source: Multi Media by Denise Lyons)

The chapter continues with the findings and analysis related to the ideological influences on the identity of the worker and their experience of subjection through the disciplinary power of regulation and the influence of dominant ideologies of new managerialism and the medical model of care.

5.6 Ideological Influences on the Experience of Social Care Workers in Practice

Social care workers are on the frontline, working with people directly impacted by welfare ideologies and changes in policy (Marx, 1867/2009; Nescolarde-Selva et al., 2017). One of the aims of the study was to discover the ideological influences on the specific settings and how this has impacted service provision and the workers' experience of practice. There are several key issues raised by the social care workers in this study, which are consistent with the literature on the impact of neoliberalism within other sectors including social work and education (Rose, 1998; Clarke, 2004a; Scharff, 2011; Lynch, 2012, 2014; Lynch, Grummell and Devine, 2012; Houston, 2016). These themes include; the impact of fiscal retrenchment on service provision; the practice of outsourcing to the private sector; increased regulation and misdirected accountability and the potential downside of individualisation. The medical model of care is also described as a dominant ideology influencing the practice of some workers in this study. The discussion begins with the impact of austerity measures on the social care workers' experience of practice.

5.6.1 Impact of Austerity Measures on Practice

One of the publically defended acts towards increased efficiency was to cut spending (Boltanski and Chiapello, 2005; Department of Finance, 2009; Lynch 2012; Keohane and Kuhling, 2014). Fiscal retrenchment and an employment freeze affected all the workers in this study in two main ways; there are less staff on the ground to meet the service user's needs, and there is less money available to enhance their life experiences (Hardiman and MacCarthaigh, 2013; Monbiot, 2016). For example, Ava stated:

“I know a friend of mine who works in a house with six people with double cover, and if somebody rings in sick, you go on your own. You might have to wait for someone from another house to come over to help you toilet somebody, as you need two people to do that” (Ava, disability services).

It is unacceptable that a service user will have to wait for second cover before they can go to the toilet, a basic human right (Office of the United Nations High Commissioner for Human Rights, 2002). For addiction workers Joanie and Sheila, cutbacks have increased the caseloads of individual workers, which can “impact the whole organisation and it can impact on morale as well” (Joanie, Addiction Residential Service). Eddie also commented on the increased role of the worker as services coped with budget cuts “there are so little resources out there and so little supports that are offered to the young people that we are doing everything ourselves” (Eddie, Children’s Residential Care). Due to the cutbacks in staffing levels workers feel under pressure and no time to be with service users, or to even sit down and have a cup of tea together, as Ava’s comment exemplifies.

“It’s very busy and so you know they might have worked in other houses where they might sit and have a cup of tea and a chat. In this house you don’t sit and watch TV with them, you are just flat out” (Ava).

Paula works in a children’s residential centre for young people with an intellectual disability. She has witnessed increased problematic behaviours, because of inadequate staffing levels.

“When you’re trying to put your heart and soul into the job it’s a mess like. Like a simple little thing like trying to get the kids to sit at the table successfully, that is a huge accomplishment; d’ya know without them disrupting. For me that’s massive and then to see them going backwards is tough because maybe the staffing levels been reduced and you know you can’t do as much, that that’s what I hate. It’s tough, there’s a lack of resources and cutbacks, and it’s not fair, you know people are suffering. They should be putting the money in here and then it would be actually be cheaper in the long run” (Paula, disability service).

Although spending was cut and the labour force reduced, some sectors experienced a rise in service user numbers, especially the homeless sector (Department of Housing, Planning, Community and Local Government, 2016). Colm (homeless service) described his experience on the frontline of service provision, “we are meeting with clients in here now that are in mortgage arrears. Like what you see on the news, we are seeing them. We have families with mortgage arrears and relationship breakdowns”. Colm stated the Dublin City Council Central Placement Service (DCC CPS) was also adding to the difficulties his service users experienced. Workers described the negative impact of engaging with some government services when the employees on the front-line are not person-centred. The following comment from Bernie relates to the DCC CPS.

“I heard someone tell a client ‘well why don’t you go jump in the Liffey’ and sometimes they are still treated like that on the night-time telephone services depending on the worker” (Bernie).

Bernie’s statement is evidence of a Dublin City Council worker believing a homeless person is undeserving of humane treatment, dignity and respect.

Housing was also an issue for disability workers, who were unable to support people seeking to move out into independent living arrangements. Addiction workers were also unable to find accommodation for their service users with dual diagnosis, which then affected the number of new placements they could offer. Homeless services experienced changes that were both influenced by policy redesign and the impact of making changes with a limited budget. A significant change was the ability of residents to apply for a higher rent allowance beyond the rent cap to enable them to avail of accommodation in the current crisis of limited rental stock and rising rents.

Getting out in the community is part of the New Directions ethos (Health Service Executive, 2012b), but workers are less likely to bring SUs out if they are understaffed and feel they cannot support the SUs behaviours in a safe way (Adolfsson, Sydner and Fjellström, 2010). Participants also stated that as a result of the recruitment embargo and slow turnover of staff, the existing staff have become older, which may have an impact on the worker being physically able to bring people out on their own. The workers' sense of powerlessness due to structural issues is compounded by their feelings of being physically unsafe or unsupported.

5.6.2 Outsourcing to the Private Sector

A significant change in social care provision is the introduction of private services. Social care services have changed from state subsidiarity, with services outsourced to the Catholic Church, to state managerialism, with services contracted out to private companies (O'Sullivan, 2005; Mulkeen, 2016). The rationale for the marketisation of state services was that private companies are flexible, cheap, and can quickly adapt to the presenting circumstances (Barnes and Hugman, 2002; Hallstedt and Högström, 2009; Mulkeen, 2016). As Sarah outlines:

“The industry has gone through a lot of changes. They have this central referrals thing now, they have closed a lot of HSE units, the HSE units obviously take the easier kids, and the others are farmed out, but there is a real difference in the kids that we get, there's not a difference in the referrals per se because the issues will still be absconding, drinking, drugs, prostitution whatever, but the level of exposure to that is higher and usually at a younger age” (Sarah, children's residential care).

The HSE offered tenders to private social care organisations to acquire possession of a number of beds in private services, and once purchased the HSE could place their

children within those units. The perception here, as stated by Sarah, is that the ‘privates’ are farmed out the more challenging children, and that there may be less opportunity, or desire, due to financial losses, for private residential services to refuse a placement, “because kids bring in the most money” (Paula). Ava used to work for the HSE in children’s residential services, however, after returning from travelling, she got a social care worker post in a private service.

“I found that some of the children in this service, not all of the children in the private sector, but some of them just did what they wanted, whatever they wanted no matter what you tried to put in place to support them. It was different, I think it had changed, the whole setting, and I think at the end of that job there the private thing really disillusioned me because I didn’t feel they were really supportive of the young people” (Ava).

The use of private companies for the provision of social care services is a contentious issue which centrally relates to the workers’ identification with the idea the practice of supporting and caring for others is for self-worth, not profit. For example, Ava spoke of her experience of being part of a team of social care workers in this private agency:

“The staff were wonderful, they had had a very good staff team but the organisation themselves, I felt were out for the money and when push came to shove the money would have been chosen over the children’s needs, and I was probably disillusioned with that” (Ava).

Paula works for a HSE house for children with a disability. She argued that state services are suffering since the introduction of private companies.

Paula “But then just at the moment with things with the HSE and adult placements it’s very hard because of funding and things like that, and that’s why everybody is in kind of limbo. We’re not the only organisation it’s happened to. It’s happening everywhere at the moment, so it’s very hard then for more to come in. And what’s happening at the moment there is a lot of referrals for the kids

to come in but the HSE don't have the money to fund them in residential, so we try now to keep them in the home or foster placements”.

Paula “Which will eventually break down, and they will end up having to come to residential, so it is a kind of a waste of money in the long run”.

Denise And you're a HSE house?

Paula “Yeah., The private companies will undercut the likes of my organisation, so that's why it's kind of hard as well, it's very competitive, it's like a business, and it's awful to look at it that way but it is a business, and it's whoever comes back with the best price and the best deal”.

Amanda (Training Officer) is also worried about the move towards the privatisation of care.

“The whole move into the private side of it also concerns me because I think we have gone backwards and it's not specific to any particular private provider but it's just become so disjointed and fragmented, and there's no consistency. They are private for profit, and I am just concerned for the kids. It's just a bit hit and miss”.

The recruitment embargo in social care led to an increase in the use of private agency staff to fill staff vacancies. Although all of the participants in the study are in full-time employment, Emma recalled an early experience of being an agency worker. “As an agency worker, I got mostly child care work. I worked in services providing 'special arrangements' which is quite a difficult one, people only last a couple of weeks, and they are gone” (Emma). This is consistent with the view that the quick turnaround of staff and the temporary nature of agency contracts will limit the ability of the agency worker to develop relationships with the service users (Cantwell and Power, 2016). A serious concern was raised by participants who stated that they and their colleagues are afraid to call in sick because they know the agency staff will not know how to work with their residents. Among the predominantly negative comments on the impact of agency workers, Emma provided the following positive point; “working agency work and working for state agencies within the HSE and then moving into private, I

saw more therapeutic work being done within the private sector”. Emma was relating to the red tape involved in HSE ‘Purchase to Pay’⁷¹ policy, and the need to have three quotes when applying for additional services (HSE, 2006). The chapter continues with a discussion on the impact of the shift in identity from service user to consumer and the further rise of ‘individualisation’ (Houston, 2016).

5.6.3 Individualisation and Resistance through the Relationship

The changing discourses in social care reflect the shifting ideologies governing practice. Alice is a worker in a day service for adults with an intellectual disability, and her responses to the question of what her experience of social care is in her service were as follows:

“I guess the role has changed over the last few years, when I went in initially you were kind of supervising contracts, and there was very much a customer based focused and that has changed over the years now to more service user focused, I mean there is a big change on now around individualised supports and I am doing training around that at the moment” (Alice).

“Services were fitting people in; now you are trying to adapt that and fit around the person, there is more a service user focus” (Alice).

There were dramatic changes in Alice’s sector, where the initial focus was on securing private contracts to create employment for the service users, which moved to developing training programmes and now the service has shifted again towards ‘active citizenship’ and the “uneasy relationship between freedom” and the service user’s ability to be free (Edwards, 2017, p. 208). There is an indication of a change in the ideology behind the provision of services, from consumerism to citizenship, where the

⁷¹ The Purchase to Pay (HSE, 2016) is a policy that requires all Government funded organisations to make a submission for funding with three relevant quotes.

service user has the right to be supported in making choices, and the service then adapts to meet a person's individual needs. This appears to be good practice. But there remains a consumer-based issue when the policy, in reality, does not have the service user's best interests at heart, for example, the Direct Payments plan (Department of Health, 2010). This plan pays the full disability allowance directly to the adult with a disability, including their services budget, and depending on the individual's disability the payment may be collected by a guardian. The rationale argued that Direct Payments increased the choices available to the person to select from all the services, rather than being linked to just one provider. This plan was mentioned by staff stating that they encountered difficulties when families were reluctant to hand over money belonging to their adult child for the services they required.

“Money and finance is a big issue and trying to get money. At the minute, I am trying to get more money off parents basically. Their parents get their money for them, and so it was always a case of if we want something we have to talk nice to the parent's kind of, so just trying to push at the minute to try and get a bit more control (Olivia).

This is a sensitive issue, and it is very difficult for staff to ask the parents for their adult child's money. In this example, the policy has not increased choice but implemented another layer between the service user and them exercising their own choice. Glasby and Littlechild, (2013) argued that the policy appeared successful, but again, there is a continued assumption here that the person being questioned (the service user) is a free and autonomous consumer, fully able to exercise their right to make choices.

Workers are aware of the challenges of individualisation and evident from Alice's statements; she has found a way to support the service user through this shift in mentality.

"I think you become a bit of a detective because you are trying to get to know people in a little bit of a different way now, trying to really establish what it is that they want to do with their life and for some people that aren't able to express that you are trying to discover that in a different way you are trying to find out that information by spending time with people and that's not what services did before" (Alice).

What Alice is describing is the practice of exceeding the expectation of the new managerialism view of the service user as an independent consumer, by using the relationship to support the service user to make choices. Using her instinct, Alice is aware that the service user is not a free, autonomous consumer (Roulstone and Morgan, 2009; Edwards, 2017) able to make their own choices, and Alice knows it is her role to support them to make decisions, through the relationship. The chapter continues with the next themes to emerge, the role of regulation, achieved through surveillance.

5.6.4 Regulation and Surveillance

As discussed in Chapter Two, Pat Brennan wrote to the Department of Education in 1973 requesting statutory registration for social care workers. This was the time of the Kennedy Report (Department of Education, 1970) and the recommendations argued that workers required training and regulation to restore the public's confidence in them. This was regulation for protection and accountability, embraced by the social care profession wanting to protect service users. However, regulation is also a disciplinary power exercised through the mechanisms of codes, documentation,

surveillance and self-surveillance (Foucault, 1977/1995). In 1999 the Social Services Inspectorate was established, to regulate children's residential care, and ensure that the new standards (from the 1991 Child Care Act) were being met, and children were protected and well cared for. As noted, the SSI was replaced by HIQA (Health Information and Quality Authority) in 2007, and the majority of participants had negative experiences of being inspected by HIQA, with most workers stating it was a disruptive intrusion to service provision. The monitoring and inspection process was viewed as a pressure because it raised the level of stress in the unit, and kept staff in the office and away from the service users. For example, Rita stated, "HIQA has taken over everybody's minds at the moment, but do you know what, HIQA could be gone in 10 years' time, it's a load of nonsense, it's a money spinner" (Rita, disability services).

Workers also described the increased role of doing paperwork, which has created a "field of documentation", especially since the introduction of statutory regulation and HIQA (Foucault, 1977/1995, p. 189). The main criticism of the increased paperwork was "taking people away from the front line ... you have to spend so much time documenting everything...it's a bit heavy handed" (Rita, disability service). Amanda began working in residential child care in 1981, she spoke of the changes in recording from when she started to when she left, twenty years later.

"So by the time I left we had a diary for every child, we had least seven. You probably know all the records now, sanction book, medication book, maintenance book you name it we said we had to kind of get wheelbarrow to bring all the books up to meeting room. And that was for me kind of very sad, because while I knew it was necessary, it took away from the potential to use the staff to let's get stuck in and, you know, spend more time with the kids, so that was kind of difficult" (Amanda).

Foucault (1977/1995) argued that recording details about people and coding them is a mechanism of disciplinary power that emerged from the development of specialist disciplines, in particular, the medical professional. The mechanisms of power, for example, documentation, recording and coding people, eventually became embedded into everyday practice and the influence of this power over the workers' behaviour became invisible. For Eddie, paperwork and recording has become normalised into social care work, experienced as a "habit by the staff". Eddie's fear is that regulation has pushed out "the risk, to a point where it's not beneficial to the young people". This relates to Smith et al. (2013) who argue that the normal 'messaging-up', which is part of learning during children's formative years in residential care, is now viewed as too risky and must be controlled. Workers are also aware that they are being regulated and are under surveillance, and this has influenced their practice towards being risk-averse over care, where they self-survey and then avoid potential risks (Foucault, 1977/1995; Smith et al., 2013). This is evident in the following comment from Eddie;

"I am very strong about systems, and we fall down on the systems a lot because I think once, if you get systems in place you are not being rigid to them, I know I am saying about not being institutionalised but there is so much, so much governance with monitoring and the policies that we have to follow" (Eddie, children's residential care).

Also, the procedures demanded from HIQA appeared to favour a medical model of care, with clear recordable tasks and outcomes, and according to Rita, the procedural demands were "too ridiculous for words". The next section describes another influence on practice; accountability measures and the impact of what is valued and by whom.

5.6.5 Accountability - What Practice is Valued and by Whom?

As stated, through the marketisation of care, people are often defined as consumers (McLaughlin, 2009), and social care settings as businesses, which changes the focus of how the State, through HIQA, defines and measures quality assurance and outcomes (Clarke et al., 2007; HIQA, 2012). The new managerialism approach to accountability changes how ‘outcomes’ are defined (Biesta, 2004), how they are valued and by whom (Kline and Preston-Shoot, 2012). The social care workers didn’t speak directly to ‘outcomes’, and only four workers included the term in their responses. However, the normalising of mechanisms of disciplinary power for example record keeping, and using behaviour plans to code and formalise people (Foucault, 1975/1995; Edwards and Fernández, 2017) is changing the behaviour of social care workers and managers, to devalue the core of their own practice, relating and spending time with service users, in favour of ‘measurable outcomes’ (Wren, 2003; Kline and Preston-Shoot, 2012). This quote from Emma highlights an important issue in how managerialism has impacted social care practice.

“You form a relationship with these clients you are working with, but also you need the balance, and this the other side of it. You need to balance your credibility, so you are showing what you are doing, so documenting stuff, that’s a really good piece of work. Being able to balance what they have to do. They may have a list of five things that they have to do during the day on top of what they normally do, and it’s like ok how do you balance that, and it’s about just getting organised. If you walk into a unit and you see it’s chaotic you know that team is chaotic, you know the house is chaotic. Even if you walk into a setting that’s dirty, I have a thing that if I walk into the house in the morning, I expect that there’s a lovely smell coming out. If it’s clean, it doesn’t look like it’s messy and I think the main aim is being able to create a home that you can put young people in” (Emma).

Although Emma acknowledged the role of the relationship in social care, what she defined as *balance*, was a devaluing of the relationship in favour of measurable

outcomes. There is a requirement to be *showing what you are doing*. The message for workers in this unit is that time spent with the young people is less valuable than the completion of the ‘five tasks’ and messiness is a sign that the team are *chaotic*. The five more things may include cleaning, paperwork and recording what happened in the day and what you did with the young person. This is an example of how Emma is sustaining, through her own actions, the mechanisms of power and discipline (Foucault, 1977/1995). Smith et al. (2013) argue that messiness is a necessary part of these young people experiences, which helps them to learn and grow. I imagine that workers in the unit are focused on ensuring that the house smells and looks clean in the morning, irrespective of how the night went with the young people, or what came up for them. When Emma said, on top of ‘*what they normally do*’, the normal activity here is laying the foundational blocks for a trusting relationship, which is core to the work and shouldn’t be undervalued. As a manager, Emma is under pressure to show (the hierarchy of management, HIQA), that she and her team are doing something. Ava (disability) also felt that pressure;

“HIQA are saying, if you say you are doing it, tell us you are doing it, and we want to see the proof that you are doing it, it's not good enough to tell us that it's being done, it is to try and look at everything like that now and so that we are showing we are doing it “(Ava).

Eddie, who is a manager in a children’s residential centre like Emma, had a different attitude to defining what ‘accountable work’ is in his setting.

“There are much more important things to be done than worrying about whether a clothes horse has been there for three days with clothes on it and that will never change. I have worked with managers who asked, ‘why is this not tidied up’, there are so much more important things that can be happening than that, the clothes horse might still be sitting there, but massively important conversations could have gone on that morning” (Eddie).

The central difference here is that the manager Eddie has an awareness that cleaning is not to be valued above the relational work of social care, and the *much more important things that can be happening* enabling time for potential conversations. Eddie gave an example of how important it is to understand what activities to value in social care practice.

“One of the girls that lives here, she was going into respite, so she was staying here the odd weekend, and she was back and forward. Her whole life was upside down. It was Saturday night, I was on shift, and we all sat watching TV, X-Factor was on. 40 minutes of complete silence and nobody spoke, then she rolled over on the sofa, and she said ‘I think I would like to live here full time’, and I said ‘well we will speak to your social worker on Monday and we will get that moving and see what we can do for you’. ‘Grand thanks’, she rolled back over and carried on watching the TV. She probably took that 40 minutes to build herself to say that out loud, and all we did was sit there. What if I’d been off cleaning the kitchen or making sure the clothes horse was empty” (Eddie).

Sarah, along with the other twenty-five respondents, including Emma, talked about their relationship as both the process and the outcome. It was all about time, spending time hanging out with the service users (Digney and Smart, 2014).

“We’d built up a relationship, spent time with him building up trust with him ...and it was actually just spending time with him and working hard on it. Like Rome wasn’t built in a day and also part of the job is like baby steps you know” (Paula).

“I just love hanging out with them because it makes sense” (Sarah).

“A lot of it was me just saying nothing, bizarrely, it was a very, very intense moment and we rolled this wave, we really did, 2 ½ hours...just kind of hanging in there” (Mary).

This activity is not tangible, or easy to document as ‘work’, ‘progress’, or something that you have ‘done’ with your time while on shift. How can workers account for the time they spend and the possible ‘outcomes’ of the valuable activity of hanging-out and hanging-in (Garfat and Fulcher, 2012; De Lissoy, 2013), unless the

management has an awareness of this role and consider this activity within their recordable accountability measurements. The next section describes the workers' awareness of power relations, and how they struggled with liminal situations in practice.

5.6.6 Betwixt and Between: Changes within Liminal Situations and Practices

Evident from the discussion within this chapter, social care workers are also self-surveying subjects who have internalised the normalising mechanisms and dominant ideologies of the neoliberal agenda. Foucault (1977/1995) asserts that resistance is complexified by the decentralisation of power, which has become embedded in social institutions and the social body, and almost impossible to see, so when people resist, it appears fragmented and unpredictable. Participants, like Eddie, experience awareness of their own subjection, as a liminal situation, when they are betwixt and between obeying policies, even when they feel they are not in the service user's best interests, or are in opposition to their 'daimon' and sense of agency (Waterman, 2011). Jim (homeless services), provides an example; "according to the rules and regulations they [people who are homeless and in Jim's service] have six months, the truth of the matters is that is that we throw that rulebook out the window because it's ridiculous because all it does is create a revolving door, that's all it creates" (Jim). Workers are torn between obeying the policies they have internalised within the subjugated self, and appeasing the anxiousness they feel when the policies are juxtaposed to their internal beliefs.

Resistance was also evident in the practices that workers avoided. Mary (children's residential care) spoke of the experienced workers she knows who are resisting the HSE guidelines to restrain children, and are avoiding using the physical restraint technique of Therapeutic Crisis Intervention [TCI].

“What has happened on the floor I think, is that people have passively resisted”.

“The vast majority of my colleagues in every house or area have certs to say they can't do the physicals [of TCI] so they will get refreshed on the de-escalating techniques and behaviour management, but they will opt out of by virtue of being not medically fit to do physical interventions” (Mary).

Mary believes people are resisting doing restraints because they are 'ethically uncomfortable' doing them. Importantly, Mary also noted that TCI is the only practice training that the workers are regularly updated in. She pointed out that a lot of work has gone into updating information technology and record keeping, but very little work is done looking at practice on the floor. The chapter continues with the influence of medical models of care and remnant ideologies on current care practice.

5.6.7 Residual Ideology of Undeserving Poor and Medical Model

There was no evidence of a significant influence by the remnants of an overtly Catholic ideology in the workers' day-to-day experience of social care practice or of a lingering dogma on the undeserving poor (Harvey, 2007; Kelly, 2016). However, the architecture of spaces inherited from historical, sociopolitical conditions are discussed in Chapter 7. Furthermore, there are some examples of a negative attitude towards service users availing of homeless services, more than any other service. Being deemed undeserving, either in the past or present appears to have more of a

unifying effect between the sectors, than becoming a source of difference. The workers who had adopted the ‘social care worker way’ in homeless services were similar in their description of practice to workers in both children’s residential care and in the disability sector.

Another dominant ideology negatively influencing the workers’ experience of practice of social care workers was the medical model of care. For example, disability workers Rita, Simon, Paula and Alice are influenced to some extent by this model. Rita argued that the medical model was prevalent “even though it’s not a *medical house*”, her individual unit, although independent, was part of a larger organisation and vulnerable to the sweeping application of universal policies that were written with an emphasis on the medical model of care. Simon also experienced the “social model at local level, but medical model at organisational level”. “The medical side have an awful lot of power, an awful lot of say in what goes on with regard to policy and procedure” (Simon). It appears that many large organisations function through the use of universal policies which do not suit all the service users. Also, it highlighted the lack of autonomy in individual units to modify general policies to suit the service users at a local level. The medical model in Paula’s organisation is experienced through “the use of Applied Behaviour Analysis (ABA) and Positive Behaviour Support (PBS) plans in use by social care workers”. The use of behavioural plans by social care workers is a testament to the increasing use of behavioural psychologists on the multi-disciplinary teams and their impact on the day-to-day practice of social care workers. Embedded in the medical model are examples of how social care workers are now using psychological tools for coding and measuring behaviour in their care practice.

Figure 5.3 presents the diversification of the 26 social care services in this study along a continuum from a social model to a medical model.

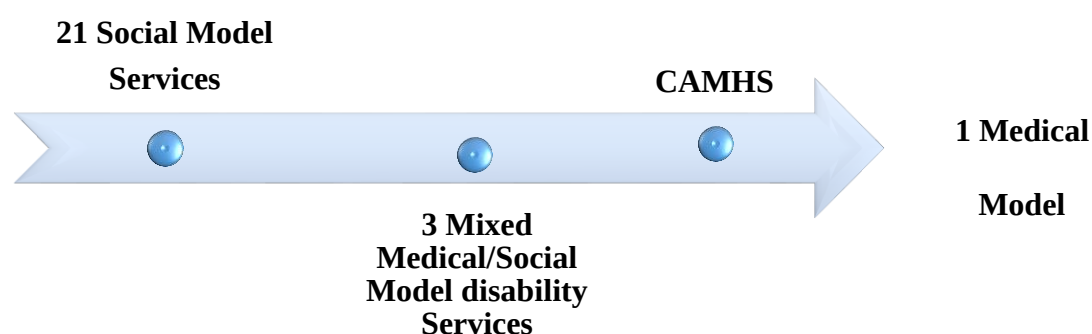


Figure 5.3 Social Model to Medical Model Continuum

Presented as a continuum in Figure 5.3, the left-hand side or social model includes; children’s residential care, homeless settings, addiction services and some disability services (21 Services). The descriptions of the practice relationship were more homogenous from the workers in services with a social model and strongly influenced the characteristics of relational work (Ruch et al., 2010; Digney and Smart, 2014). The centre of Figure 5.3 reflects the dual ideology of three disability services where the social care worker can practice under a social model while working collaboratively with their medical colleagues in the service. For example, Alice suggested that both models were evident in her day service, and although the “medical model is still very prevalent but I am lucky to have a manager who has got a social care background”. The right-hand side of the diagram reflects the services where medicalised hierarchies of power prevailed. These organisations had the most structural resistance to ‘the social care relationship’, either by the medical and psychological techniques that

effectively reduce the autonomy and power of the social care workers there (Edwards, 2017).

The descriptions of the social care relationship differed between workers influenced by a social model of care and the medical model. I had difficulty placing the workers in Child and Adolescent Mental Health CAMHS on the continuum. The CAMHS participants in this study work in a medical setting, under a medical hierarchy, however, their work is also centred around the relationship they develop with their young clients. The key difference is that they described the relationship as therapeutic, which was different to the way the other workers' described their way of being in a relationship with others. It may be difficult for CORU to include CAMHS workers as people engaged in social care work when both their practice and further education has evolved into the realm of therapy. It is possible in time that CAMHS workers will register as part of the eclectic counselling and psychotherapy registration board of CORU under a title more fitting to their specialised practice. These workers are competing with professionals whose 'judgements' are formally recognised by the social structures and institutions (Foucault, 1977/1995; Edwards and Fernández, 2017), and it was the worker's own identification with social care as their own identity that was causing their quandary. The discussion in this section concludes with the workers' perception of a hierarchy between the different professions on their multi-disciplinary team, especially the medical disciplines, which also influences the workers' experience of practice.

5.6.8 The Status of Social Care

Several participants spoke of being very aware of how social care was viewed by others, and how it was viewed as having less prestige or status than other helping professions. Garfat and Charles (2012) described this as the identity of child and youth care workers in the past, who were viewed as a ‘sub-profession’ or “extensions of other helping professionals” (Garfat and Fulcher, 2012, p. 7). However, participants in this study described this as their current experience, especially workers in the disability sector. It is possible that the physical care tasks of caring for people in the disability sector aligns social care workers with the lower qualified care assistant role as opposed to being perceived as on par with nurses (Welter, 1966; Cott, 1977; Chambers, 1987; Lavender, 1998; Lynch-Brennan, 2009). The most alarming response came from Paula who manages three residential services for children with a disability.

“When I started working, I felt totally out of my depth. I felt everything I had studied went out the window. My status as SCW was never fully recognised. We as SCWs were looked down upon by clinicians and nurses. Basically, we were viewed as the scrubbers. What would we know? I know it may sound harsh. I still feel to this day the role of SCW is not taken serious or recognised. Possibly the title might need to change. For me, I still feel I have to fight every day to have my title and qualification recognised the same as anyone else. I am currently a manager of three designated centres for disabilities and have a track record of four registered centres within 12 months by HIQA. I also have an MSc, but my qualification is not viewed as being adequate by nurses or clinicians as mentioned above. I see on a daily basis these group of individuals being placed on a pedestal yet I am still classed as a nobody because I don't have a fancy title. I believe there is a view out there that SCWs are nobodies. What could they be able to contribute? They just clean, cook dinners and tend to daily tasks. I also believe there is a level of ignorance towards SCWs by people who don't know or don't want to know what our role/job is. Hopefully one day there won't be such negative connotations towards SCWs, and we will be recognised as professionals. Until this happens, it's very hard to identify as a SCW”.

Paula stated that she felt less respected than her colleagues in nursing and other caring professions. There is a value system within society that places the medical/scientific opinion above others, including the ‘patients’ themselves, because these experts are “integrated into the very body of the state apparatus” (Foucault, 1977/1995, p. 116). This lack of professional recognition has affected Paula’s ability to self-identify as a professional, irrespective of the additional qualifications she has gained since becoming a social care worker. Paula also spoke of not having the points initially to pursue her first passion nursing and used a FETAC level 6 course as a stepping stone onto a social care degree programme. Even though the Masters in Social Science is a level 9 qualification, Paula still felt perceived as inadequate *a nobody*, when compared to her peers in the multi-disciplinary team. Evident within the discussion on academic achievements (see 5.2.4), many participants spoke of their poor academic achievement leaving secondary school, and of not achieving the points for their first choices of social work, psychology or nursing. I am wondering if these social care workers feel professionally inadequate when they compare themselves to the workers in the professions they initially wanted to become, irrespective of their subsequent achievements and qualifications.

Ava, Emma, Paula, Laura, Joanie and Joan’s social care work on the floor is to some extent guided by behavioural support plans, and these workers are often limited in making decisions unless they are approved first by the Behavioural clinician or team. The behavioural ‘codes’ are examples of the machinery of control which are secreted into the practice of other disciplines, which act as “an apparatus of observation, recording and training”, for the service user and the social care worker (Foucault, 1977/1995, p. 175). As Sarah (children’s residential care) stated there are

“lots of doctorates floating around” and many workers described how they needed to run everything past the behavioural support team or clinical staff in the organisation. Sarah believed that the experience of ‘superiority’ from the clinical professionals is changing, suggested in the following statement.

“There is already a relationship established, and in my view, they need us more than we need them because they are not on the ground doing it...we are the family effectively, we hold the information so they can spout what they want recommendation wise but the recommendations have to go into place from us, so I think there is a mutual respect there, yeah, I mean a lot better than it was way back then”.

Central to Sarah’s point was her acknowledgement that what is unique about the profession of social care is that workers’ *hold the information*, which they have gathered through spending time and relating to the service user. Mary also described the shift of recognition for workers in children’s residential care, to a more egalitarian inter-agency approach. Eddie (children’s residential care) believes that all social care workers should be seen as equals within the multidisciplinary team.

“We are not ringing them [social workers] for them to tell us what to do and we are not ringing them to tell them what to do. We are working together, and we should be seen, and we are professional, and we are entitled to our professional opinion. I feel very strongly about that, and I push the team on that, but whether that’s how it’s perceived, I have never felt the opposite, I have never felt that I wasn’t being treated as an equal in a management position. I know some of it is down to my personality”.

When Eddie talks, he speaks with professional confidence, I did not hear this as arrogance, but as an acknowledgement that social care workers know the young people better, because they have spent time with them and have developed a relationship. This is what is unique about social care because it is this profession that gets to develop a relationship with the service user, to spend the time needed to really listen and learn. Thirty plus years later, some social care workers are still experiencing a lack of

professional recognition for social care work within inter-agency collaborations. Garfat and Fulcher (2012, p. 7) assert that through the ‘passage of time’ and/or the development of a “distinct method of practice”, their workers are now acknowledged for the important contribution they make based on their knowledge and expertise in working with young people and families. It is very difficult for individual workers or managers to defend their professional opinions if they do not have a strong sense of who they are, and the importance of their contribution to the overall care of a service user, and how their specific role contributes to inter-agency care.

“Being a SCW, to me, also means that other professions need to recognise it as a qualified profession and have respect for it. I think it is our job as SCW’s to fight for our qualification and stand up and be proud of it. We need to break any stigma that is attached to it. We as SCW’s are professions and have trained the same as other disciplines. As a SCW I will fight for other SCW’s and stand up for us” (Paula, disability service for children).

5.7 Conclusion

The majority of the twenty-six workers wanted to help people from a young age which emerged as the main motivator to become a social care worker. Social care may not have been the first choice for all workers, but they declared their satisfaction at ending up there. The fact that there are nineteen female participants are representative of the predominantly female profession of social care, and although the male participants are few (seven), the perception from the females is that they are hired for their brawn and are promoted quickly. The findings suggest that gaining experience on the floor through direct social care work with others is a rite of passage for social care as

workers transition from novice to expert, and essential for an identity claim as belonging to the profession of social care.

There is evidence of identity development during the workers' social care education especially when the college employed lecturers from the discipline of social care or invited in workers to speak to the class. The majority of workers stated their identity development was most active during the placement experience, and if they performed well, they were likely to gain employment in the placement agency. All workers demonstrated that there are multiple roles in social care, and the main roles claimed were helper, change maker, team-worker, whistleblower, observer and key-worker. Workers also spoke about how privileged they felt to be in the position to help others feel safe and cared for. All workers provided examples of how both they and the service they work in was affected by austerity measures, especially cuts to the budget and staffing levels. Workers' became aware of their subjected self through awareness of the mechanisms of power, and experiences of feeling betwixt and between obedience and resistance in the liminal situations (Foucault, 1977/1995). Regulation emerged as a dominant influence on social care workers' in different sectors, and the evidence demonstrated that regulation has moved from the idealised view of protector in the time the Kennedy Report (1970), to an awareness of its potential for control and discipline. This discussion continues in the next chapter which focuses on answering the question 'what is social care', evident from practice stories and examples structured within the three case clusters defined by the originating ideologies: the deserving, the undeserving and those subject to the social model of social care practice.

Chapter Six Experiences of Practice: What is Social Care?

6.1 Introduction

In the last chapter, the participants in this study shared their personal journeys into care, from the workers who identified with ‘caring’ from a young age, to those who stumbled upon this road by chance and never left. This chapter focuses on discovering ‘what is social care’ aided through practice stories and the use of the integrated theoretical framework of sociopolitical theory, a social pedagogical framework of Head, Hands and Heart (Brühlmeier, 2010); and Wenger’s (1998) regimes of competencies. These stories, structured within the three case clusters, are descriptions of practice that exceeds and is also constrained by the expectations, targets, recording and surveillance of new managerialism. The three case clusters are representative of the ideological origins of social care, and the diversity and broad span of social care contexts from the original setting of child care work with children in large institutions (O’Doherty, 2003) to an emerging profession (Hutchinson, 2017) in diverse settings.

Social care is presented in this chapter as holistic embodied and situated; through the engagement of the head, heart and hands. Links are made between the social care workers engagement with the relationship in their practice stories and contemporary views on ‘presence’ and the ‘co-created relationship’ from Ireland, Scotland and Canada (Doyle and Lalor, 2009, 2013; Smith, 2009, 2012; Garfat, 2008, 2012; Digney and Smart, 2014). The chapter begins with an understanding of practice through the stories workers tell.

6.2 Understanding Practice Through Story

To understand day to day practice, workers were asked to provide a story or example that is a representation of their engagement in practice. The analysis of their responses includes references to Wenger's (1998) 'regimes of competence', principles of social pedagogy and relational child and youth care (Wenger; 1998; Petrie et al., 2006; Brühlmeier, 2010; Digney and Smart, 2014). The workers' stories were structured into the three case clusters, illustrated in Table 6.1.

26 Participants in Three Case Clusters	
Group 1	Ideology of Undeserving Sectors: Homeless Services, Addiction, Youth Crime Prevention
Participants 5 Homeless (Jim, Colm, Frank, Bernie, Clare) 2 Addiction (Joanie, Sheila) 1 Youth Crime (Joan)	
Group 2	Ideology of Deserving Sectors: Disability Services, Child and Adolescent Mental Health
Participants 3 Day Services Adults with ID (Alice, Kate, Laura) 1 Outreach ID (Liam) 2 Residential Children with Physical Disability (Paula, Una) 4 Residential Adults with ID (Rita, Simon, Olivia, Ava) 2 CAMHS (Samantha, Michelle)	
Group 3	Social Model of Care Sector: Children's Residential Care
Participants 5 Children's Residential Care (Mary, Adam, Sarah, Eddie, Emma) 1 Training Officer (Previous residential worker Amanda)	

Table 6.1 Three Case Clusters

As discussed earlier in Chapter Four (section 4.6.1), the cluster structure is based on the originating ideologies and power relations influencing both the establishment of the service but also how people were treated there (Walters, 2012). This is a 'bottom-

up’ and historical structure, which takes into account that mentalities have changed, and how over time other ideologies have become influential to the provision of care in each service. It is important to note that the analysis here aimed to expose the remnant discourses and residual ideologies influencing contemporary practice social care practice (Lorenzen and Lake, 1987b; Byford et al., 2010; Garthwaite, 2011; Lalor and Share, 2013). The aim of separating social care workers into groups or clusters was to establish if the ‘social care way’ of practice has travelled from the original setting of children’s residential care in group homes and disability services, to the more recent locations of homeless and addiction settings. Otherwise, the situated learning has caused a dilution of social care to a reality of being different helping professions using the one title, and as Hutchinson (2017, p. 1) questioned “a collective of practices on a continuum”. As well as understanding practice through the stories workers tell, I wanted to look at the experiences of workers in different settings to see if social care has identifiable common themes, similar ways of working or thinking, which can be defined as ‘shared enterprises’ (Wenger, 1998). Also, this chapter explores through the stories workers tell how their practice exceeds the expectations and requirements of the dominant ideologies in both negative and positive ways.

These practice stories provide examples of mutual engagement and doing things together and thus belong to the shared repertoire of regimes of competence (Wenger, 1998). Four of these ‘stories from practice’ are included here, the remaining 22 stories are presented in full as Appendix 6. The first practice story is from case cluster one; homeless, addiction and youth crime prevention services.

6.2.1 Practice Story (Homeless, Addiction and Youth Crime)

The homeless sector is a more recent setting for social care work, and as such workers are not commonly defined by the term ‘social care’ there. Of the five participants in this study, only two (Jim and Colm) can clearly define the role of social care in their setting. It is more common for workers in homeless services to employ people from a variety of educational backgrounds into the position of project worker, a common title in this sector. However, ‘social care’ is fitting comfortably with the role of ‘key-working’ and the one-to-one work within this sector (Seymore, 2009, 2013). Two participants in this cluster are employed in residential drug treatment centres and are identified by the titles ‘case worker’ and ‘project worker’. The last participant Joan (youth crime prevention) is defined in a similar way to those in addiction or homeless services and is called a ‘project coordinator’.

Stories of Practice in Homeless, Addiction and Youth Crime: The stories of practice from workers in the homeless and addiction services provide an insight into the workers’ experience of practice. All the stories provide examples of the worker engaged in face-to-face practice with a person in their care. These stories bring the reader into the world of the worker, made visible through the emerging themes (Krueger, 2004; Barkham, Hardy and Mellor-Clark, 2010). The common themes that emerged were the existence of meaningful practice moments, the difficulties workers’ experienced in staying present and hanging-in with people, and the importance of active listening, and acknowledging mistakes. The final themes relate to the self-gratification workers experienced from a ‘breakthrough’ in their relationship. Interestingly, the key themes emerging from the practice stories are similar to the central themes of relational practice (Garfat and Fulcher, 2012; Smith et al., 2013). In

all of the stories provided, the example is based on something that happened within the relationship between the worker and the service user. I have included one story from Jim (Figure 6.1) as an example of practice within the homeless sector.

We had a great student here last year, lovely young kid. We hit it off and we were sitting chatting there the second or third week she was in and we were having a chat and I was saying 'how are you getting on down stairs? She said 'I love it, but I feel so unable, your key workers are brilliant and they are so good' and I said 'what makes them brilliant and good', she said 'they just get on so well with everyone and everyone loves them' and I said 'it is because they built relationships with people'. 'You have relationships at home, who do you get on with, who in your family? She said her mam, she loved her mam, but she had a very special relationship with her granddad. She loved her granddad to the point that she could barely contain the tears when she was talking about him, and I said 'well there you are, you have now got something in your toolbox'. I said 'we have an old man who has just come to live with us, he is 70 years of age and he is sitting downstairs, you go down and introduce yourself to him. She was here for 16 weeks, and they had an amazing relationship, just to watch it, every time she walked in the door his face lit up. This man came straight here from prison. He had spent 10 years in prison for murder, pretty serious individual. I didn't tell her any of that because it wasn't important and she used all her learnt skills from the relationship with her own grandparents to have a relationship with that man. She finished up her placement here, and went back to college. When she finished her degree, I rang her and asked her to come in and give us a couple of hours, and she walked in the door and he spotted her and he started crying. It was just, it brings tears to my eyes, it was just beautiful, it was absolutely beautiful, and I said to her before she left, do you remember that conversation we had very early on about how you had seen everyone else as better than you, and I said look at Frank (pseudonym) today.

Figure 6.1 Practice Story One: Jim (homeless services)

Central to Jim's story was the relationship between the young student and the older male resident. The student was in her third year and Frank, the resident, was an ex-prisoner, who after finishing his custodial sentence became homeless and was now living in the homeless hostel. Jim had withheld information about the past life of this

resident, stating that it was not relevant. This decision was based on Jim's assessment of the actual risk to the student on placement, and the likelihood of this information colouring the relationship. Here Jim is practising relationship based work, over being risk-averse (Smith et al., 2013). This decision is indicative of Jim's understanding that stigma is reduced through increased contact and learning to 'see' the person first (Corrigan and Penn, 1999). The practice story captures the gradual process involved in developing a relationship, spending time together, linking in, sharing spaces and memories (Trevithick, 2003; Ruch, 2010). For the student, the visible success of the relationship enhanced her confidence in her ability to become a social care worker; she was feeling the reward for her personal expressiveness (Waterman, 2011). For the service user, he experienced the relationship as genuine (McHugh and Meenan, 2013), and made a real lasting connection with the young student. It is evident from the practice story how the relationship the emerged between these two unlikely 'companions' exceeded both their expectations. The story also shows that Frank has stayed in the service beyond the recommended six-month maximum time permitted, which demonstrates how frontline staff are forced to ignore this unrealistic policy in the current homelessness crisis. Finally, Jim's consideration towards the student's experience on placement is a worthy example of the important role of the social care worker as an educator.

6.2.2 Practice Story Two: Disability Services and Adolescent Mental Health

The disability/mental health group consists of the largest number of participants in the study (two working with children in residential, four in adult day services, four in residential for adults and two in child and adolescent mental health). Disability

services are one of the two traditional social care sectors (Lalor and Share, 2013; Finnerty, 2013). However, it is important to note that in the 1990s untrained disability workers joined child care courses that existed since 1974, and as Ava recalls “I was so frustrated with (Lecturer on disability studies) that I stood up in class and shouted, No, that is not what happens in a disability service, and people started clapping”. The participants within this study work in residential services for either children or adults (Finnerty, 2009), respite services (Harvey, 2007) and day services (Paul, 2014). Disability Services generally have a clinical multi-disciplinary team with the inclusion of professionals from the disciplines of nursing, psychology and occupational therapy. Disability services also employ more care assistants than the other settings, to provide for the physical and intimate care needs of service users (Dustagheer, Harding and McMahon, 2005). Care assistants are lower paid than social care workers and are not required to have the level 7 QQI social care qualification⁷² (Kacen, 2005). Social care workers are also employed as part of the multi-disciplinary team within CAMHS, and this has proved difficult for the two workers from this sector who are participants in this cluster. Understanding what is social care within the disability and mental health sectors begins with the common themes which emerged from the thematic approach to the narrative analysis (Barkham et al., 2010) of their practice stories.

Stories of Practice in Disability and Mental Health Settings: The main themes within the disability workers’ stories of practice were emotional connections, dealing with grief and a sense of failing, and examples of presence and of paying attention to meaningful moments (Digney and Smart, 2014). Practice Story Two is

⁷² Ordinary Degree in Social Care

from Simon, a manager in a residential service for adults with physical and intellectual disabilities (Figure 6.2).

We have one service user who is non-verbal and finding an IP goal (individual plan) for her was very difficult, because she has no verbal communication, she is not able to communicate in a lot of ways. You can still get a certain amount of communication out of her, but very minimal communication, and I suppose when it came to her IP goals it was a case of trying to learn them, to be patient and sit down. Accepting it takes a bit longer to come up with something and like that we came up with massage therapy for her and reflexology and it's something she really loves now. That took a very long time to get to that. It sounds very simple but at the same time if you have got somebody who can't turn around and say, 'I would really like a massage', it's not something that necessarily pops into your head because it's not something that I would be looking for in my life. She is now having a massage once a month and you can tell because she smiles again that she is very relaxed. That is something we have got right for her and like I said, it's an ongoing thing to try and continuously find little things that she likes to do and it is a challenge because at the end of the day it's always good to have somebody saying I really like what you did there and to reinforce and go yea we are on the right track, when you don't have that you are sort of guessing and going ok what if we get this wrong, so there is a bit of responsibility there but I suppose with her it would be coming down to the staff team knowing her well and to sort of knowing that when she smiles it's a good thing, you know what I mean fairly simple sorts of bits and pieces but to be aware to watch out for (Simon, disability services).

Figure 6.2 Practice Story Two: Simon (residential service for adults)

Simon provides an example of how staff are engaged with the documentation of Individual Planning IPs outlined in the New Directions Report (Health Service Executive, 2012b). The service meets the service user's needs through the identification of goals that are recorded as achievable outcomes on the person's individual plan. Simon's story demonstrated that in some cases it is difficult to fit each within this scientific/rational tool. However, Simon's story highlighted how knowing the service user well helps this process. But relationship development can be difficult, especially if the person is non-verbal and you need time to learn what they need through guessing the 'non-verbal cues' (Race, 2007; Finnerty, 2013). The mechanisms of policy and regulation, "engages them in a whole mass of documents", and as such, there is less time to learn what IP goals the service user needs and can achieve

(Foucault, 1977/1995, p.189). The final stories are from the last cluster; children's residential care.

6.2.3 Practice Stories from Children's Residential Care

Residential care was the first social care setting, beginning as predominantly female, untrained and low-paid child care work (O'Mahony, 2002; Gilligan, 2009; McHugh and Meenan, 2013), and for nearly twenty years their educational programme was structured specifically around their training needs. Five participants in this study work in children's residential care and I have included Amanda the training officer in this cluster because of her many years as a social care worker in this sector. Residential care is currently provided in houses, mostly within housing estates and workers in this sector provide for the day to day educational, physical, social, emotional, spiritual, medical needs of the young people in their care (McHugh and Meenan, 2013).

Stories of Practice in Children's Residential Care: The main theme to emerge from the practice stories in children's residential care was the importance of spending time with young people, and how the pressure of managerialism is impacting on the essence of the work. Workers are not just about providing for the needs of young people in their care, they have a purposeful job to do, 'to get to the nitty-gritty' (Sarah), in a short timeframe before the young person becomes eighteen and has to leave the service (Figure 6.3).

Over the first week I kind of observed everything going on and thought, ok, on paper everything looked amazing, the kids went to bed on time, there was no incidents, you know, there was very little that would flag this house up and I called a staff meeting and I said ok I am going to start pinching a few kids because actually you are not getting to the nitty gritty with them. Their life is just on hold and while that's really good actually we have very limited time to do the work that we need to do with them. So this one kid was sitting in the corner, he was a little rocker, long curly hair, a kid that was really trying really hard to make people not like him, he was smelly, he dressed funny, he just didn't want the world to like him and I decided I was talking him on as a project because his key worker didn't like him. I called a meeting with her and she said but I don't like him and I said well you know what, you are paid to like him, find something about that child to like and come back here in a week and tell me what it is because that's your job, you are a social care worker, you are paid to like this child and if you are not capable doing that then you need to not be a social care worker. So, she came back after a week and she had found something to like about him and actually it grew into a lovely relationship and this kid lived with us for five years after this. But he was a self-harmer and they were so intimidated by the self-harming element. They thought he was just weird. I said he's not weird he's hurt and so I walked in, gave him his elastic, his red marker, his journal and whatever, and said this is how you are going to do it and there is your medi-wipes so you need to tell us when you cut yourself, the kid went into shock, the team went into shock, the social worker went deadly that's me off the hook and I mean that kid is part of my life now, you know, but watching the key worker get the relationship was just amazing because no-one had ever told she wasn't allowed to not like kids, what the f**k are you doing in social care if you don't like kids, you can't pick and choose.

Figure 6.3 Practice Story Three: Sarah (children's residential care)

Initially, the whole staff team was challenged on their engagement with the young people, highlighting the importance of *getting to the nitty gritty* to move beyond rational accountability and safe practices and become more relational (Doherty, Horne and Wootton, 2014). Sarah's practice story was centred around one young person, who was not liked by his key-worker, an opinion reflected in the whole team. Sarah challenged the key-worker to *find something she liked*, which ultimately led to the development of an amazing relationship between them, the key-worker understood how to 'get the relationship' (Ormond, 2014). I am not sure if the key-worker shared her dislike of her key-child by accident, or because she felt safe and supported to do

so. It is important to note that having feelings of not liking the service users is deemed as outside the acceptable discourse of social care practice, but it is a reality of practice which needs support and a space to express their liminality safely, as they are still transitioning in their own professional development (Thomassen, 2014; Burton, 2015). I included a second practice story here Figure 6.4, because I felt the role of the relationship in social care is worthy of emphasis. Mary's story is set in the car, one of the most popular practice spaces for social care work, discussed later in section 7.3.2 (Ferguson, 2009).

I keep thinking of that young one that I worked with. This young person had been on an access visit with her brother in another residential unit, a high support one, and it hadn't gone well for her and we were driving back to our own place. It was a very traumatic time for her, they were talking about moving this brother into our house and even though both children were very keen on this, we knew it really wouldn't work. I feel that she felt more scared than excited, but couldn't articulate it, and there was an incident in the car, she got very physically aggressive in the car with me. So I pulled over, for safety, and we spent two and a half hours odd hours in the car together while she just went ballistic. I remember I was texting colleagues trying to keep them clued in on what was happening, and she endeavoured to assault me a couple of times and a lot of it was me just saying nothing, bizarrely, it was a very, very intense moment and we rolled this wave, we really did, two and a half hours in the car at the side of the road, just kind of hanging in there. She kept threatening to get out and go and she would open the door and close it again, I just knew she needed to stay, she needed to work this out and we got to the other side of it. I kind of thought thanks be to goodness it happened with us here in this space where we could do that because if we were back in the house it would be different, the dynamic, other young people would have been involved.

You are conscious the whole time of the vulnerability of yourself in this moment with this young person on your own, the unexpected kind of eruption at the side of a road, you know all of that. It's a very important moment in my head, because I rode that way with her, through this very, very important time in her life, and the outcome was positive. We manage risk, we assess situations in split seconds, that is the head part, you know, and you are gauging it, texting with colleagues and trying to gauge whether or not I need assistance, whether not I want them to call the guards, whether or not they need to, this sort of stuff and the whole time knowing the risk you are carrying, but knowing that the payoff could be really helpful to this young person, even if it's just to your relationship with this young person, just a tiny micro-bit of trust that they didn't have at the beginning.

Figure 6.4 Practice Story Four: Mary (children's residential care)

Mary's story is centred around one young person in residential care. She is currently separated from her brother who is in a different unit, and she has an outburst in the car when trying to process her feelings about living with him again. Mary's story is about the 'social care relationship', this unique relationship that understands when it is important to 'hang-in' with the situation because this moment could mean so much to the person and to the development of their relationship (Garfat and Fulcher, 2012; Digney and Smart, 2014). Mary was assaulted in the car, but she assessed the risk in this situation and chose to stay. The car acted as a container, a non-threatening space for this important work (Ferguson, 2009, 2010). This is very different to the situation experienced by workers today where violence against staff is tolerated and viewed as part of the role (HSA, 2014; Keogh and Byrne, 2016). It is worthy of note that high-stress situations can focus the meaning-making experience for both the worker and service user and "serve as insight-building experiences" (Ranahan, 2017, p. 9), which is true in this case as Mary *keeps thinking of that young one*.

All the practice stories provided examples of social care practice, where the relationship enabled workers to go beyond the limitations of policy. This provided an experience that exceeded the service users and in some cases the worker's expectations. The common theme was that practice through story was defined as 'doing with other'. Figure 6.5 depicts the warmth that I could see expressed through the interviews as workers told their practice stories and remembered all the people who resonated with them. The connection was genuine and the feelings expressed were real. Social care workers are; through their words, actions and emotions, connected to the people that they work with, be they young people, service users, the lads, the residents, or the clients, within a specific space and place. This study aimed

to capture what social care is, from the stories people tell about their practice, to embrace all that is unique, wonderful and challenging about this diverse and humbling profession. The underlying theme of social care from the practice stories is the role and purposeful use of the relationship as learning, knowing, key-working, being there, holding memories and hanging out.



Figure 6.5 *“I think that's very much what it's about, interaction really” (Joan).*

“I would just put two people sitting in front of each other because it shows that one is talking and somebody is listening. I think that's very much what it's about it's about, interaction really. Meeting somebody face to face, social care is only so much, if you can't interact with people you are not going to last in this profession” (Joan).

The chapter continues with examples of the metaphors workers provided to illustrate their practice.

6.3 Metaphors for Social Care Practice

Social care workers were asked if the cover from ‘*Social Care -Learning from Practice*’ by Howard and Lyons (2014) was representative of their experience of social care, within their practice setting. The photograph was used to stimulate critical reflection (Harper, 1988; Mannay, 2016), in a visual way, thus identifying what social care is in that specific context, by seeing an image of something it may not be. The response to this arts-based research method was fascinating. Every worker provided at least one metaphor to explain their practice, but also the context and environment in which the practice happens. The metaphors that relate to the workers’ experience of practice are presented here, and those related to the contexts of care are located within Chapter Seven. Most workers provided me with visual descriptions of symbols which represented their practice, and I created drawings to show how I imagined them.

The most common metaphors from the research participants in the three case clusters included symbols for learning (books), symbols of emotional attachment (drawings, personal photographs), and connection (cup of tea, arms holding and sometimes pushing on), and metaphors to reflect their thoughts and feelings about the service users (rose for resilience). I have included examples of the metaphors, illustrated through drawings within each case cluster, and the remainder are presented in more detail as Appendix 5.

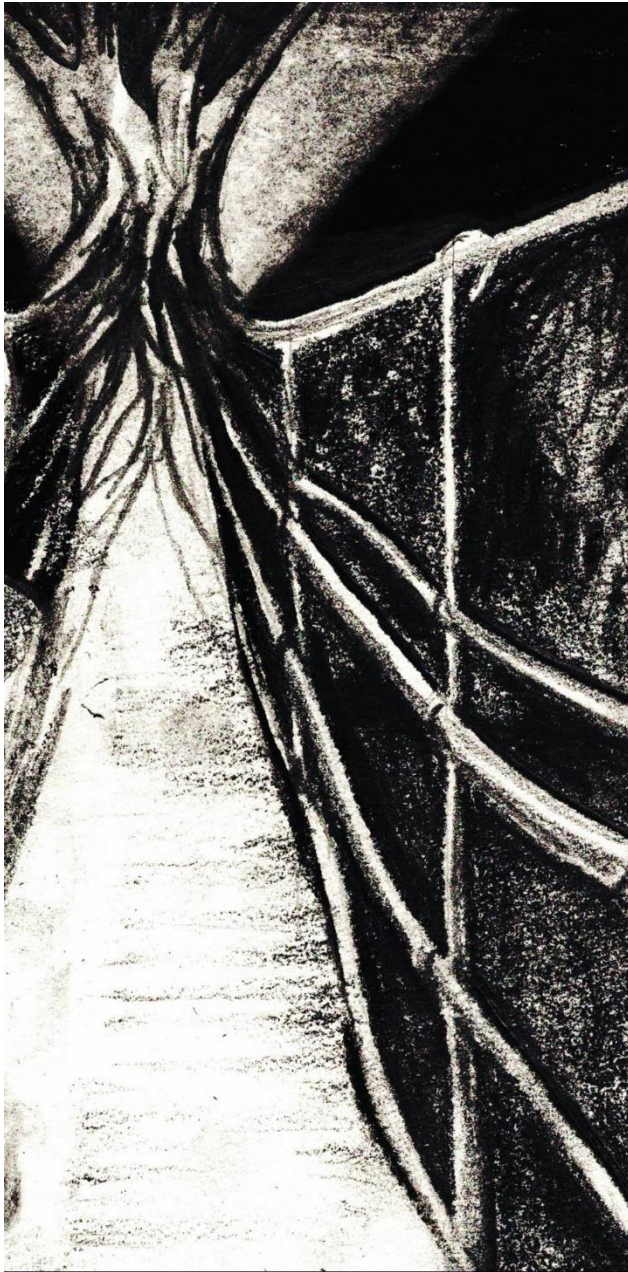
6.3.1 Photo Elicitation Themes from Homeless and Addiction Services

Case Cluster One has eight participants and represents the community based sector in this study (five from homeless services, two from addiction and one youth crime worker). The most common practice themes to emerge from the photo elicitation

process were; moving on and transitions, connecting and interacting face to face, dealing with death and grief, and keeping hopeful for the future. The following practice metaphors emerged from the workers in this cluster.

- **Candle:** “Kind of light of hope or you know, something that's welcoming” (Jim).
- **Rope Bridge:** “Clients move on, it's about the way forward, pushing forward” (Colm).
- **One Word ‘Respect’:** “If I don't respect the clients I am working with they are not going to respect me” (Joan).
- **Hand reaching for the Stars:** “A hand reaching out to the stars saying just go for it”.

Colm’s image of the wooden rope bridge is illustrated in Figure 6.6, which evokes a sense of risk and tension that the resident must take before they reach the illuminated tree in the distance. Going forward towards this unknown landscape is mirrored in Frank’s metaphor of the hand reaching towards the sky in Figure 6.7. Both participants described the images as representing aspirations of the future for their residents, where the residents will go beyond the service and out into their unknown futures. They also used words like ‘striving to move on’ pushing the residents to go forward, but where they were going was unknown, or out of their control, the future was conceived and imagined (Tuan, 2012). Pushing service users towards an unknown future lends itself to dreamlike or metaphysical images that are also beyond the control of the worker and the service user.



“A rope bridge with wood, you know the kind of wooden bridge that’s barely there, but at the end of it is a big tree and opening with sunlight it’s about looking out the window at the way forward” (Colm, Homeless Service).

Figure 6.6 Tree at the end of the Bridge (Source: Pencil drawing by Denise Lyons).

The next drawing, Figure 6.7, is a hand reaching for the stars, and this is another reference to the tension between being optimistic and fearful for the service users’ future.



“A hand reaching out to the stars saying just go for it. There is a huge anxiety, they are not sure what’s around the corner, they have 101 questions about their past that are unanswered, But, if they can look beyond the fear which is very difficult, just to give them that bit of gentle push in the right direction saying here just go for it. Take control, set where you want to go, make these positive changes. If they can look beyond the fear, which is very difficult, just to give them that bit of gentle push in the right direction” (Frank).

Figure 6.7 Reaching for the Stars (Source: Pencil drawing by Denise Lyons)

The image ‘reach for the stars’ captures the reoccurring theme within the homeless, addiction and aftercare services, the need to encourage the residents to reach and move forward into the unknown space. The workers appreciated how difficult this move was for the service users, but understood that they needed to push them towards their unknown future. The next metaphor illustrated here is a candle in Figure 6.8, and two workers in this study (homeless sector and addiction) represented the theme of

death and grief using the symbol of a candle. The discourse on the use of this symbol demonstrated the emotional impact of engaging fully in social care, with your heart, as well as your head (Petrie et al., 2006) and how dealing with loss is also a part of being a social care worker.

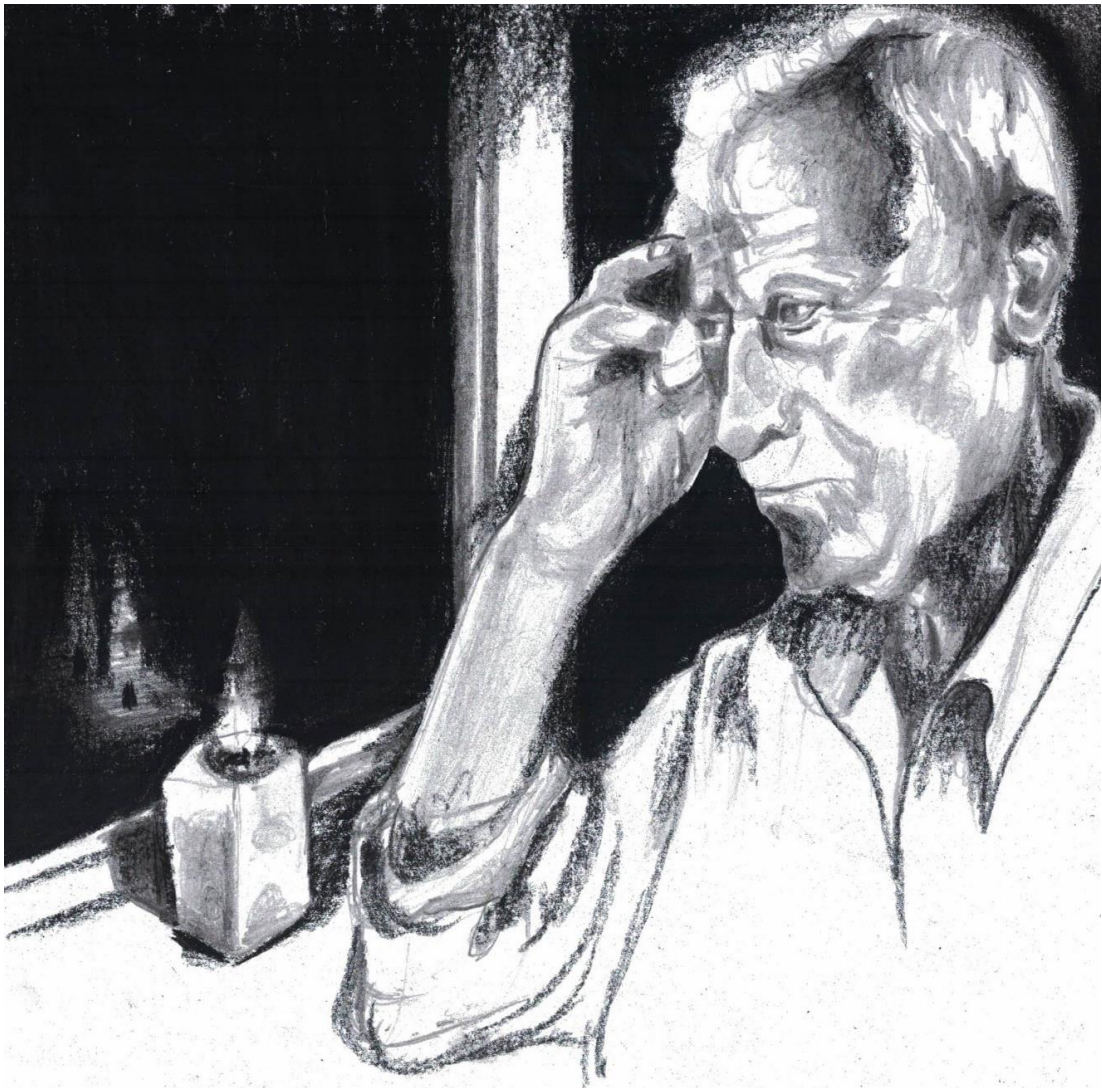


Figure 6.8 A Candle in the Window (Source: Pencil drawing by Denise Lyons)

“One of the people that lived with us lost his place here due to very unsafe drug use, and he died very close by. The guys downstairs decided that they would honour him to by putting a lighted candle in the window, just honour that space, so as not to be religious and all that, and I thought it was very profound. They lit it every morning, and they left it there until they burnt it down to the bottom. Kind of light of hope or you know, something that's welcoming” (Jim).

I drew this image when I came home after the interview with Jim. I cried during the interview when he told me the story of the ex-resident who died very near the centre. I was embarrassed and felt unprofessional because I showed emotion during the interview, but I could not avoid empathising with the interviewee who was so openly and candidly expressing the emotions he felt, on the death of a resident that they could not help. Being with people in social care is being human and forming attachments and feeling love and loss (Hutchison, 2004), like the other residents expressed when they put a candle in the window, in memory. Sheila (addiction service) used the candle to describe the importance of hope because there is also sadness in her work.

“There can be something quite solemn about looking at a candle you can pick up a little bit of sadness from people. Light that shines from a candle represents hope, having hope as a worker in addiction is extremely important because relapse happens quite a lot. Even when you are working with somebody for a very long time, and you feel that they are doing well, they disappear off the scene, or maybe they die. It's about hanging onto that hope. Once that flame goes out I will know that it's my time to go” (Sheila).

The candle represented the sadness she sometimes feels and the ‘hope’ she aspires to give the people she is currently engaged in practice with. The chapter continues with the themes that emerged from the photo elicitation of workers in the disability and mental health sectors.

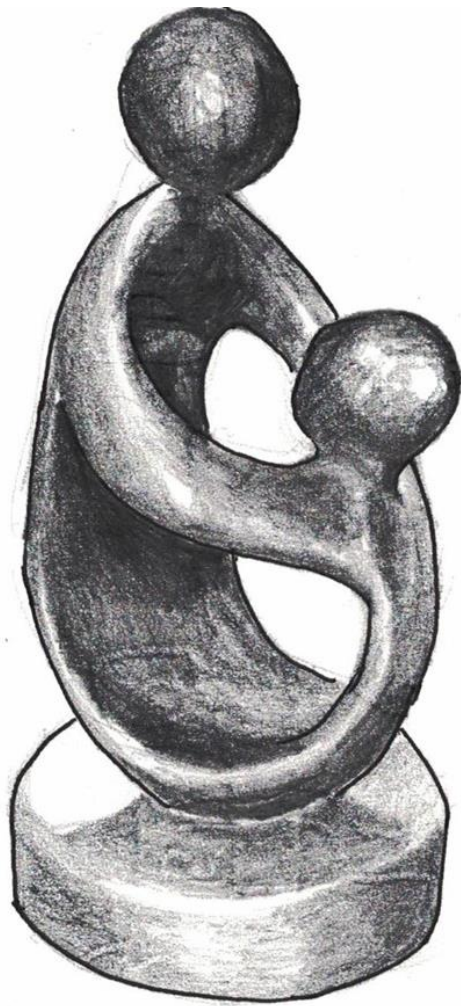
6.3.2 Photo Elicitation Themes Disability Service

The main practice themes to emerge in the second case cluster (the disability sector and CAMHS workers) related to caring, expressing care, holding and letting go, creating meaningful moments and feelings about the vulnerability and resilience of the service users. The following is a list of the metaphors provided by the workers in

this cluster and the descriptions they gave.

- **A Teddy Bear / A book / Map of the world:** “The teddy bear is caring, the book is learning, and the map of the world would represent their push forward” (Simon).
- **African figure:** “The circle isn’t closed, you know just to show that there is support but also that there is an opening for independence” (Kate).
- **A Cup of Tea:** “Our best chats, we get information, we get people to relax and calm down” (Laura).
- **A Single White Rose:** “People we work with are very vulnerable and very resilient” (Alice).
- **Big Arms Around the Whole Person:** “It’s holistic, it’s the whole person you have to mind, it’s their emotional needs, their physical needs, their social needs. It’s not just the minding; sometimes you have to push people” (Rita).
- **Big Caring Hands:** “It’s just very much a symbol of support, care and I’m thinking of the warmth of hands” (Michelle).

There are two drawings of the main themes that emerged from the photo elicitation process, beginning with Figure 6.9 an African statue symbolising care but also recognising the importance of treating adults with a disability like adults, and letting them go and live their own independent life. Pushing forward is also a theme that emerged in the metaphors of workers in the disability sector. In this cluster, the workers were not imagining pushing their service users towards an unknown future, but towards increased independence.



“We kind of help people communicate where they are at and that way they are able to move forward as best they can. African figure a mother and child, the mother is encircling the child, there is an openness as well, maybe the circle isn’t closed, you know just to show that there is support but also that there is an opening for independence, an opening for forward-thinking” (Kate).

Figure 6.9 The African Statue – (Source: Pencil drawing by Denise Lyons).

Both Alice (Figure 6.10 on the following page) and Kate presented a symbol of their services users as both vulnerable and resilient, with the challenge for the worker in protecting and caring, and also supporting people towards increased independence (Finnerty, 2013). Workers in the disability sectors talked about the increased managerialism (Kline and Preston-Shoot, 2012; Lynch, 2012) which is having a negative impact on their ability to spend time with the service users which is necessary for the gradually work needed in preparing the service user to be more independent.



“A rose, it's beautiful and maybe a white one, because it represents purity and a lot of people that we work with are very vulnerable and a flower then is vulnerable itself. A rose because it has thorns in it. I think a lot of the people that we work with are very resilient to be able to put up with the different changes that have occurred. The more we see things from people's perspectives, the more we grow” (Alice).

Figure 6.10 The Rose - (Source: Pencil drawing by Denise Lyons).

Alice also used her metaphor to stress the importance of the learning role of the worker, and when we see the world from the perspective of the service user, *the more we grow*. The chapter continues with the metaphors from the final cluster; social care practice within children's residential care.

6.3.3 Photo Elicitation Themes Children's Residential Care

The final cluster (children's residential care) has the smallest number of participants in this study, despite being the first sector that social care work emerged from. The following list are the practice metaphors provided by five of the six workers in this group.

- **A Cactus:** "I have cactus in my staff meeting rooms because it takes negativity...then we can all have very open conversations about the needs without anyone getting insulted or upset" (Sarah).
- **Photos and Drawings on the Fridge:** "Photos are memories for them... drawings made on family visits are put on the fridge" (Emma).
- **A Rubix Cube:** "As social care can be quite complex in solving certain issues, however, once patience and time is put into solving a problem it can seem easier to practice and complete" (Adam).
- **A Book:** "Stuff changes and every page you turn is new information and the idea of being open" (Mary).
- **The Word 'Acceptance':** "Accepting difference, so just accept them, rather than trying to change them" (Olivia).

There were also symbols used for the impact of engaging in the process of social care work and how the work writes itself onto the pages of the worker, becoming part of the mechanism involved in the ordering of worker as the subject (Foucault, 1977/1995). Acceptance and having a sense of humour was also relevant to practice in this setting (Digney and Smart, 2014). There are three metaphors illustrated as drawings from this cluster, the word 'Respect' (see Figure 6.11), 'The Worker as an Open Book' (see Figure 6.12) and 'Social Care: A Rubix Solution' (Figure 6.13). Olivia included the word 'acceptance' as her metaphor on the importance of the workers' attitude which was similar to Joan (addiction service) who believed in treating people equally and in trying to instil a sense of respect for people from the young men she worked with. Both workers believed in being a role model, as a way of being in practice, and as such both ideas are presented together in Figure 6.11.



Respect

“I would try and put up a word, respect, because if I don't respect the clients I am working with they are not going to respect me” (Joan).

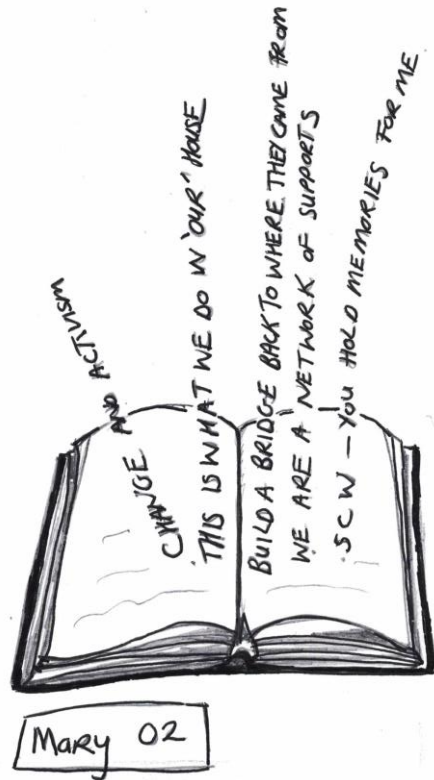
Acceptance

“I suppose accepting differences and I think as well with adults, it relates specifically to adults because they are never going to change, that's what they are” (Olivia).

Figure 6.11 The Importance of Acceptance and Respect (Source: Pencil drawing by Denise Lyons).

Both Joan and Olivia used metaphors to illustrate the importance of being self-aware and constantly checking-in with their own attitudes towards the service users.

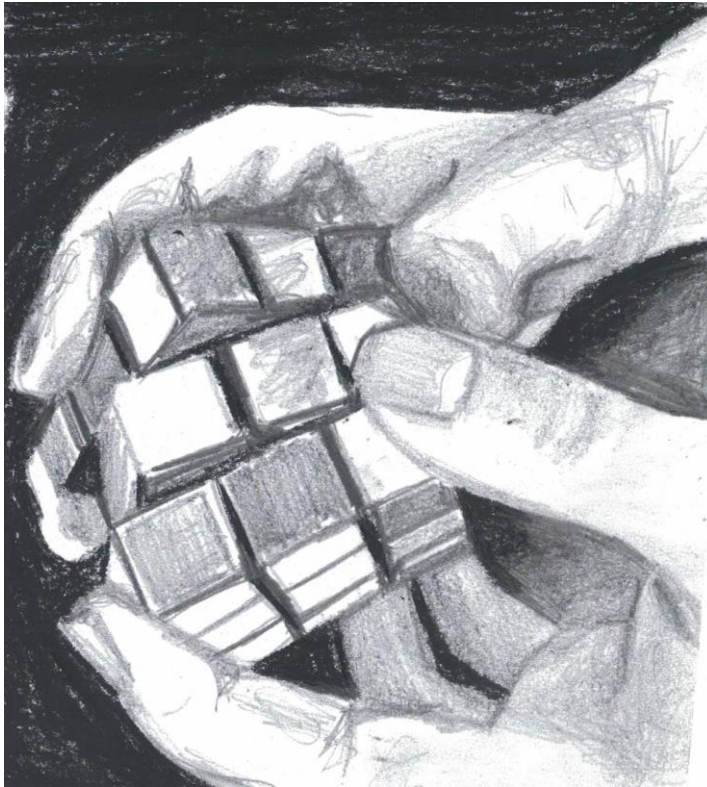
Figure 6.12, is an image of a book, and this was a symbol that Mary said reflected her feelings about the work and her own identity in practice. Books represent knowledge, but also the sense that workers are an open page, ready to be ‘written on’ each day. Mary’s symbol also represents the recording of care, which has formalised people as cases, as worker’s write the life story of their services users in the book of records (Foucault, 1977/1995). There is so much power in recording the lives of others and workers need to constantly check their recording for bias and subjectiveness (Hugman, 1991, 2005).



“Stuff changes and every page you turn is new information and the idea of being open. A blank book, it's yet to be written. I have come to own my own practice so my book would be about me as much as it is social care” (Mary).

Figure 6.12 The Worker as an Open Book (Source: Pencil drawing by Denise Lyons).

Mary described the book as a metaphor for remaining open to new experiences but also making sure that the worker tries to maintain links with the service users' past, their families and memories, their story. Books can also be a symbol for the role of the worker as an educator for the service user in the skills for everyday living, and for students to teach them the shared and indigenous enterprises of social care practice (Wenger, 1998). The final practice theme illustrated here in Figure 6.13 provides an overview of social care practice as requiring patience and time in the same way you would address the challenge of completing a Rubix cube puzzle.



“I’m picking a Rubix cube, as social care can be quite complex in solving certain issues however, once patience and time is put into solving a problem it can seem easier to practice and complete. The Rubix cube can represent a young person as well as a staff member” (Adam).

Figure 6.13 Social Care: A Rubix Solution (Pencil Drawing by Denise Lyons)

Adam originally provided a ‘hammer’ as his metaphor, and then he laughed and changed it to the Rubix cube. Humour is also part of the puzzle of doing social care work with others (Digney and Smart, 2014). The chapter continues with an exploration of the significance of the framework from social pedagogy (Petrie et al., 2006) and relational child and youth care (Garfat and Fulcher, 2012) to Irish social care practice as a way of learning what practices may be shared, or indigenous to the setting (Wenger, 1998).

6.4 Embodied Practice: Indigenous and Shared Enterprises

Social care workers are in pursuit of enterprises or practices that are ‘indigenous’ to their specific setting, or will be similar between the settings and thus defined as ‘shared

enterprises' (Lave and Wenger, 1991; Wenger, 1998). Discussed in Chapter Three, social care workers will be examined by the *standards of proficiency* (CORU, 2017b) to ascertain their fitness to practise. The standards from Domain 5, which relates to the professional knowledge and skills are included here as another representation of social care. The shared enterprises of practice and some indigenous enterprises that emerged within the embodied, holistic practice of twenty-six interviews are presented here using the structure of the triptych of head, hand and heart (Brühlmeier, 2010; Cameron and Moss, 2011). These enterprises are contested and informed, through the integrated lens, based on an understanding of the situated learning and the sociopolitical conditions that frame the official expectations of practice.

6.4.1 Head -Active Meaning Making

Head relates to the knowledge needed for practice, also described as the 'thinking stage' within the therapeutic daily-life experiences of child and youth care (Digney and Smart, 2014). Head also refers to the cognitive and purposeful engagement in meaning making with others (Wenger, 1998). The knowledge required for social care practice is context specific, but some themes relate to all sectors. Through mutual engagement, workers establish the knowledge base within their setting, which is negotiated, exchanged and emphasised between the members of the staff team within the service (Wenger, 1998). Amanda (training officer) stated that in the 1980s when she started college there was an emphasis on theory and legislation, but she felt that college needed to look more at "soft skills...what you need to do to be with these kids...self-awareness and self-development".

“The one very strong piece that was there was art and drama that kind of gave us a whole new insight into myself and stuff even that we could use for the kids” (Amanda).

Alice (disability service) described the common-sense workers need for social care work and the importance of being cognitively engaged. This did not denote the common sense rationalism of new managerialism (Smith, 2009). Rather, it referred to always questioning and “trying to get to know what people want”, “using your head” (Alice). As Ava (disability services) states, social care workers need to “keep asking questions, ‘are we missing something’, reading the situation, reading their [the service users] messages and writing down what works”. This questioning is a form of resistance (Houston, 2016) to the subjected self and the embedded mechanisms of new managerialism, especially in a time of increased individualisation where the focus has shifted from service user to active citizenship. For Mary (children’s residential care) the head was the moment by moment assessment of the risk to her personal safety, the split-second decisions that are commonplace within the work (Munro, 2008).

The shared enterprises that inform the knowledge base of social care includes how workers have collectively experienced a retrenchment of service provision based on the austerity measures of neoliberalism, and have witnessed the inappropriate use of agency staff in services for people who need an established relationship based on trust and familiarity with their caregiver. Workers in all services are experiencing the impact of increased regulation with the time they have to spend with others, and how this time may not be valued by these external forces. Also, the increased documentation and technical/rational approach to the accountability of practice is also a shared experience between the settings. The standards of proficiency guide the worker towards scientific and technical/rational knowledges, however, there appears

to be limited emphasis on encouraging the worker to have an awareness of the influence of dominant ideologies on their practice, beyond using a rights based approach. Although the majority of workers describe their practice based on need, the principles of social justice, advocacy and empowerment are evident throughout their statements. The second pillar of the social pedagogical/child and youth care frame includes the areas of practice that workers' identified as engaging their heart, values and beliefs

6.4.2 Heart -Emotional Nature of the Work

All the comments related to using the heart in social care, describe the workers' emotional involvement, thought the experience of being with the other. The heart includes all references to being in a relationship, and the values and beliefs of the worker, which are needed for practice. The heart is the area that binds social care workers together and is the main shared enterprise of social care work. The majority of comments related to being in a relationship with another person (Krueger, 2004), you have to "be in tune with your emotions" (Frank), they are a guide (Ward, 2010), and the work "can break your heart at times" (Una, Disability Services). As Jim (Homeless Services) stated "my heart is invested here" and for Joanie also from a homeless service, "I would get quite emotional at times because I care but that's what motivates me, so there is a huge part of my heart involved". Social care workers are emotionally invested in their work with others. Described as the "emotional cost of doing the work" (Ava, Disability Services), the respondents were aware of the impact of the work on their own emotions. Social care work involves emotional connections; care, grief and being non-judgemental was described as one of the characteristics

central to the relationship. Bernie (Homeless Services) explained how she had to keep her own emotions in check in order to be non-judgemental of the man she was developing a relationship with as part of her practice.

“When I was working in [a homeless service], I met the father of a child that I previously worked with in [children’s residential care service] and she had been horrifically abused by him, horrifically sexually abused by him and he came into the shelter and he was talking to me and it clicked with me who he was. He had a big hole in his finger, and I was doing first aid on it, and it clicked me who he was, I nearly wanted to poke my finger in this hole, but you know, like that you just have to take a breath and say this is my job, I am there to support this person as he is here right now. He started to talk about how concerned he was about the child, who was a teenager now, that his teenage daughter was off doing drugs and he thought she was prostituting and all of this kind of stuff, and what’s going on in my head as well why do you think that happened? You know what I mean, I think that’s probably the most difficult judgement call I have had, and I did have to reflect on it afterwards and talk to my supervisor to just kind of talk it through, but once I had done that, you bring it back, you take the emotion away from it and you bring it back to, well, this is what I am here to do, and I have job. I don’t have to like every single person that I work with, but I do have to treat them with the dignity and respect that I would anybody else, and I have to do my job. Sometimes it’s harder, but for the most part, I think if you take away people’s offences you can find something to like in anybody, most people are likeable somewhere” (Bernie).

Bernie knew that it was essential for her to have a non-judgemental attitude towards her service user, she noted that this was difficult and she used supervision to *talk it through*. Some settings appeared to evoke more challenging emotional responses for the interviewees, especially children’s residential care and homeless services. For Ava (Disability Services) the emotional cost of the work became too much, too painful (McMahon, 2010) and she left one setting to work in another. For her, children’s residential services were the most emotionally demanding of the sectors.

“There is an emotional cost to working with kids in care, all that that entails, knowing what happened to them, knowing people abandoned them, knowing

that nobody else cared about them in the world really, other than paid staff who were only going to care for them for a period of time. I just think the work had taken its toll on me and by that point, I was not able for that level of emotions. As much as you can have controlled emotional involvement, it does take a toll on you seeing a person being treated like that” (Ava, Disability Services).

The weight of this responsibility can have an impact on the worker both emotionally and physically (Munro, 2008). “The potential to do good or to do damage is huge” (Amanda, Training Officer) and workers described feeling exhausted, worn out, taking sick leave, feeling burnt out, feeling sad and emotional during the shift, and feeling frustrated and helpless. There was also an overwhelming sense of connection and being emotionally connected to those they cared for (McMahon, 2010). Workers spoke of loving the job, and how privileged they felt to be in the role of social care worker. Love was also prominent in the language used to describe the service users’ experiences, in the things they enjoyed doing and the experiences they shared with the workers (Byrne, 2016b), but workers struggled with describing their feelings as love.

“ I remember one day he [young person in residential care] says to me ‘ you don’t give a shit about me’, ‘you don’t care about me’, and he might have even said that ‘you don’t love me’ and I said well I don’t love you because I am not related to you, I work with you and he said that you won’t be there for me when I leave and I said well realistically we won’t I said but while you are here I will do everything I can for you, and we will set up you the best we can but you have to be realistic that this is, it’s only a short-term intervention really”(Eddie).

Eddie answered the question of love directly, telling the child that he could not love him because they were not related. This was an answer, but not to the question the child was asking; ‘can they not love’ me (Smith, 2009, p.123). The language of love was present, but the workers danced around this challenging word (Garfat, 2004), trying to find a way to express ‘professionally’ how they felt about the relationships

that were meaningful to them. Worker's spoke of loving being with the service users, loving hanging out, and moments of love.

“There are moments where kids come back, and they are bringing their kids back to visit you, and they are gorgeous, and I just say you didn't make me a granny again, and there is that kind of love where you do walk away and think yeah I did something good today, there are moments of absolute madness and chaos but that's part of it, and if you can't sustain that then you really shouldn't do it” (Sarah, Children's Residential Care).

Sarah included terms of family, 'me a granny again', viewing these grown-up children as relatives, as they bring their own families home to meet the extended family. But as Sarah argues; “it is a kind of love”, or “love at a distance”, because either “the worker or the service user can just walk away”.

There are limited references to being and relating in the standards of proficiency, especially in relation to having an awareness of the emotional impact of engaging in social care work. Also, the relationship was not emphasised to the same extent, or described in a similar way to the experiences of workers in this study. Describing the relationship as 'a tool' which includes the therapeutic concepts of 'transference and counter-transference', (CORU, 2017b) does not capture the important role of the relationship in social care work, as a shared enterprise between workers in all settings, and the centre of it all.

6.4.3 Hands – Doing Physical / Intimate Care and Touch

As discussed, the head must be actively engaged in the work of social care in order to facilitate the meaning making through mutual engagement and doing things together from within the relationship (Wenger, 1998; Gilligan, 1999). Doing things together

includes the knowledge of the head and the body in practice, “long before formal knowledge, there was an intelligence of the body” (Lefebvre, 1991, p. 74). Social care is physical, and part of being embodied in the practice of social care is doing physical care tasks for the service users (Carnaby and Cambridge, 2005). The majority of the indigenous practices emerged through the discussion on what the workers do with others. They are presented under the main doings tasks and activities that workers engage in.

Doing Practical Tasks: Residential care workers spoke about cleaning (Lyons, 2013). “Lots of cleaning” (Eddie) and the practical tasks of driving, maintaining the house, painting walls, looking after the garden, and filling the skip. Dealing with a serious incident, and using physical restraint was also raised by residential social care workers. Activity was described as a way of keeping the young people busy, to avoid antisocial behaviour and damage to the property spurred-on by boredom (Kelling and Coles, 1996). Workers in homeless and addiction services also noted the practical tasks of cleaning and paperwork, but the ‘doing’ appeared more focused on the tasks of the key-working relationship, doing the Holistic Needs Assessment, being hands-on and “making the cup of tea or the sandwich” (Bernie) and sitting down chatting and listening.

Cleaning tasks were most prevalent in the responses from workers in the disability sector when describing the practical tasks of care in their setting, which also included doing budgets, cooking, washing clothes and writing a variety of reports. Providing for the physical and intimate care needs was a significant part of some worker’s experience of practice on a day-to-day basis. There was also evidence of medical tasks like dispensing medication, preparing food, thickening drinks and using

task analysis sheets based on behavioural plans which were more common in the disability services. Workers in CAMHS described specific therapeutic tasks and therapeutic work which was directly related to their clinical setting and an example of their indigenous enterprise. The most common shared enterprise involving the hands and/or body in practice was the experience of touch, which may be experienced in different ways, depending on the service users.

Physical Contact Through Touch: Touch is another common characteristic of social care work emerging from the cross-case analysis across the sectors. The most comfortable conversation in the interview when discussing touch related to the provision of personal and intimate care needs. Touching a person while you are assisting them to have a wash, go to the toilet or get dressed, was presented by workers in the disability sector, as acceptable, not an intimate touch but respectful, practical and almost mechanical (Finnerty, 2013). Providing personal and intimate care is a core activity of meeting the needs of people within the disability sector (Carnaby and Cambridge, 2006). Workers spoke of individualised care, being sensitive to the individual's level of comfortableness with being washed, fed and touched. Although workers stated that service users get used to personal and intimate care, knowing the person well, was described as essential (Carnaby and Cambridge, 2006). Touching a service user for affection or to meet their need for physical connection was also addressed by workers in the disability sector.

“The man who lives in the bungalow that is separated [from the main house] he would be quite affectionate... he needs his hugs, you can tell by him he needs an odd hug every now and again” (Ava, Disability Services).

All social care work involves face-to-face interacting on a daily basis and workers are gaining confidence in claiming back the right to use appropriate touch with service users to meet their emotional needs, because they need it (Smith, 2009). This will move the discussion about 'touch' away from the historical context of harm and abuse to a recognition of its essential role in social care practice.

“There has been real shift in the amount of hugs that go on here. Before when I started, touching a child, you couldn't do that; you needed to clear it with the court why you touched the child. If I went off for a week and came back I would hug the kids, and that's the way it should be, but within reason as well” (Eddie, children's residential care).

Eddie's comment relates to the history of abuse that has overshadowed residential care, and how staff, fearful of false allegations stopped giving young children a hug, or any form of physical affection (Gilligan, 1999). Having a no touch policy for Smith (2009) is abusive practice. For many young people in social care services being restrained was the only time that another human being touched them because all other opportunities for appropriate touch were not permitted. Touch was also raised by workers in homeless sector describing the practice as limited to the use of handshakes, hugs, Indian head massage for mindfulness and relaxation.

The final point raised on the role of the body in practice relates to the workers' experience of being physically or emotionally hurt while in work. According to Amanda violence against social care workers within the Child and Family Agency is increasing and she noted the physical and emotional impact of violence on the worker. “I suppose they are burned out really. They have had enough, enough is enough, and the fact that so many of them are being injured and nobody even starts talking about the emotional abuse that they receive, they do talk about the physical aspects of it, but

I think there's a lot of that, and that's not easy" (Amanda). Sheila and Joanie (addiction), Clare (homeless) Emma, Sarah, Mary and Amanda (children's residential care) all provided examples of assaults to themselves or other staff in their unit, which echoes Keogh and Byrne (2016) research. To surmise, Figure 6.14 illustrates all the shared and indigenous enterprises that collectively describe the situated knowledges of social care work.

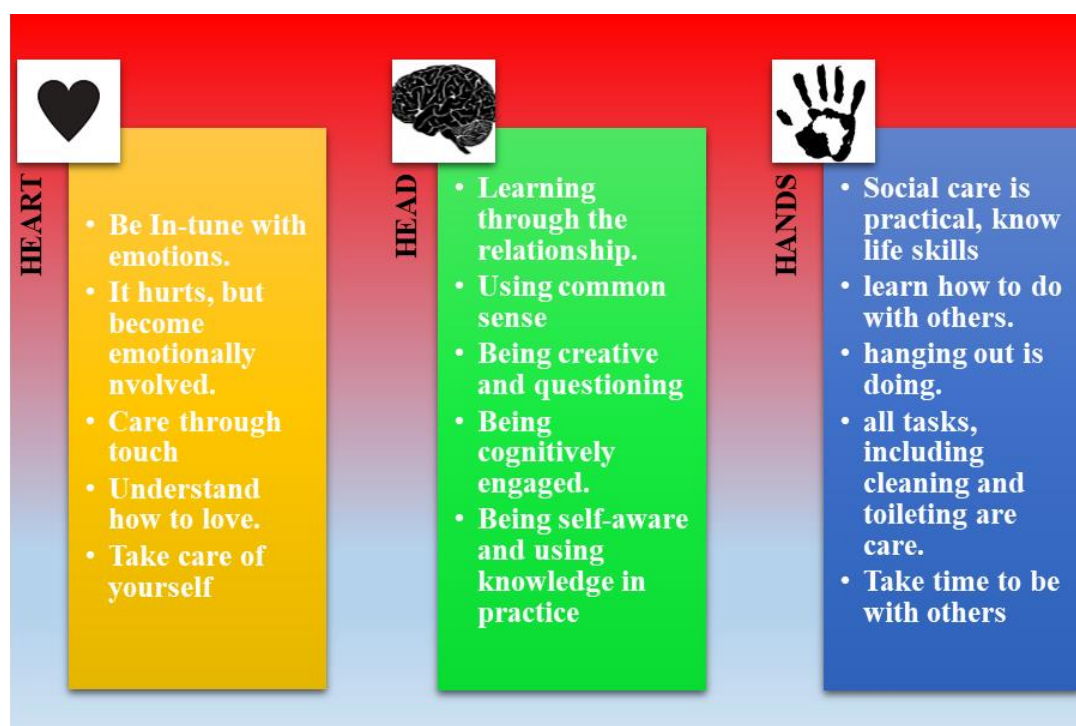


Figure 6.14 Situated Knowledges of Social Care Work

Overall the worker's experiences of day-to-day embodied practice using the head, heart and hands exceeds the standards of proficiency in terms of the regulator's understanding of the role of the relationship, the role of the situated context specific learning, the practical hands-on engagement with people through touch, the emotional impact of being in a relationship with others and an awareness of the ideological influences on practice. Figure 6.15 is a Visual Reading entitled 'Shared and

Indigenous Enterprises’, to illustrate how social care workers have knowledge that they share, irrespective of the settings, and knowledge that is specific to the service and people with whom they work. In the Visual Reading Figure 6.15, two children represent workers from different social care settings. Each child holds a bag containing the roles, skills and tasks that are indigenous to their specific setting. They also carry one bag between them, a larger bag which represents the shared enterprises that all social care workers’ possess, which includes the role of helping and supporting others, also understanding that the relationship is central to their practice, and other common ways of being and working together that emerged throughout this chapter in the practice stories and the photo elicitation process.



Figure 6.15 Visual Reading: Shared and Indigenous Enterprises

6.5 Conclusion

Workers provided examples of how they used the relationship to support service users to make choices, irrespective of the underlying ideology or policy. The relationship in practice emerged here as an antidote to the negative reality of individualisation and managerialism, and as a practice worthy of the time it needs, irrespective of its representation with the standards of proficiency (CORU, 2017b). Workers provided practice stories, metaphors and examples of their practice as it related to the head, heart and hands. The central finding is that the social care relationship is a fundamental and shared experience, which is ideally holistic and the embodiment of all three elements; head, heart and hands.

Social care work is a genuine face to face connection between the social care worker and other, through which the worker learns about the service user's needs and how they can be supported through this relationship and the overall service. There is a real fear that social care work will be 'relationally depleted' (Rushton, 2005) before the profession has acknowledged the relationship as the centre of the work. Social care workers have specialised knowledge, gained through the relationship, related to the service and the needs of the service users, residents, customers, and young people they work with, which is learned through hanging-out, sitting down, listening, connecting, being genuine and spending time together (Garfat and Fulcher, 2011). The final findings and data analysis chapter focuses on the contexts care and how different spaces and places are used for relational work with others.

Chapter Seven Contexts of Care

7.1 Introduction

The last chapter presented the embodied, situated, relationship based and holistic practice of social care, as both influenced by and exceeding the expectations of the technical/rational dominant ideologies of the medical model and neoliberalism. This chapter focuses on the influence of the context on the situated learning, which is also supported by the regimes of competence framework from communities of practice, and sociopolitical theory (Foucault, 1977/1995; Wenger; 1998; Brühlmeier, 2010; Digney and Smart, 2014).

The chapter begins with the built environment of care contexts, that have been adapted to suit current need, but as the material culture of the space involves both past and present architecture, this influences how the space is used and experienced. The chapter continues with a discussion on how workers use place and space, for example going for a drive or sharing a cup of tea in a coffee shop, in a purposeful way for their practice. Finally, understanding the workers' experience of these diverse contexts is aided through the use of metaphor and visual reading. The case clusters are also used to structure the findings and analysis of the contexts of care in this chapter.

7.2 The Built Environment and Material Culture of Social Care Places

To provide an overview of the contexts of care Table 7.1 describes the buildings which host each service and outlines the number of service users cared for in that setting, within the three case clusters.

CONTEXTS OF CARE	
CASE CLUSTER 1 (Homeless Services, Addiction, Youth Crime Prevention)	
	<ul style="list-style-type: none"> - <u>Jim</u>: Large Georgian building with six individual apartments. - <u>Colm</u>: Large Georgian building with 16 double rooms / six singles. - <u>Frank</u>: Office based and has a caseload of 15 care leavers. - <u>Bernie</u>: Large modern building with 12 temporary units and six one night only beds. - <u>Clare</u>: Office based and visits homeless families in B&B. - <u>Joanie</u>: Renovated large detached house with several buildings on private land for treatment rooms and shared activities. - <u>Sheila</u>: 75 residents in large complex with buildings for treatment services and residential purposes. - <u>Joan</u>: Large multi-purpose building for young people in the centre of a town, 6-8 individual sessions per day. -
CASE CLUSTER 2 (Disability Services, CAMHS)	
	<ul style="list-style-type: none"> - <u>Alice</u>: Large repurposed factory in an industrial estate with 63 service users and majority are over 50 years of age. - <u>Kate</u>: Large house in a residential estate with 12-16 people day. - <u>Laura</u>: One story building, residential village, 9 people per day. - <u>Liam</u>: Office based, visits service users with ID residential homes. - <u>Paula</u>: House in an estate with three children (6 to 14 years). - <u>Una</u>: Large residential units on a complex, and grounds include a school. - <u>Simon</u>: Two adjoining houses in a residential community, 3 adults in low support house and six in the high support house. - <u>Rita</u>: Detached house in residential estate, five ladies over 60. - <u>Olivia</u>: Semi-detached house in a residential estate, two female service users. - <u>Ava</u>: One detached residential house divided into two, one man on one side and two ladies on the other. - <u>Michelle</u>: Mental health day service in a community clinic old building, but large room for individual sessions. - Samantha: Part of the hospital and has 6-7 individual one hour sessions per day.
CASE CLUSTER 3: (Children's Residential Care)	
	<ul style="list-style-type: none"> - <u>Mary</u>: House in a residential estate, four children. - <u>Adam</u>: Large detached house, no neighbours, six children. - <u>Sarah</u>: Office based, manages five children's residential houses in housing estates. - <u>Eddie</u>: Detached house in an estate, four children. - <u>Emma</u>: Residential house in an estate with five children. - <u>Amanda</u>: (Past) Large detached house with over 10 children.

Table 7.1 Contexts of Care in Three Case Clusters

Evident from Table 7.1 social care provision is housed within a variety of buildings that are either physically and professionally isolated, are embedded within a community, or set out on a private complex, are small and residential or large and industrial. The chapter begins by exploring the influence of these diverse environments, multiple structures and buildings on the workers' experience of practice in the space (Lefebvre, 1991).

7.2.1 The Built Environments of Clusters One, Two and Three

Visiting the service is an important part of understanding the workers' experience of practice, and when possible the interviews took place within the workers' practice setting. In relation to case cluster one, I visited the workplaces of Jim, Colm, Joanie and Joan. Many of the services in case cluster one were established by religious orders who have a history of catering for large numbers of residents in institutional settings. As a result, homeless and addiction residential services tend to be larger and cater for more service users than the residential services from the other two clusters. The majority of workers in case cluster one are based in large buildings that are multifunctional, for example combining a residential area with treatment/activity rooms. The two addiction services in this study were geographically separate to the local residential areas and provided living and treatment services within the one private complex. Joanie works in the residential section of a drug and alcohol treatment centre for men. The centre is not visible from the road, and a tree-lined drive opens up to a whitewashed two story detached country house. The entrance is through the main building which hosts offices and treatment rooms, and after walking straight through this building, the rest of the service is visible within the adjoining buildings

that surround a small courtyard in the centre. The number of residents vary, and on the day of the interview, there were 14 residents in different stages of the programme. The bedrooms are shared, and as residents' progress through the programme, they are assigned leadership roles to support the day-to-day chores required for living and working together. I was brought on a tour through the maze of large treatment rooms and spacious living spaces by one of the resident leaders who was almost finished his programme. He spoke enthusiastically and candidly about the different therapy groups he engaged in, and how the service works on a day to day basis. His final words to me were about his appreciation of the treatment programme, and how he is looking forward to returning home for the first time in many years.

Also within case cluster one, the five homeless services were located in multiple settings ranging from the city centre beside businesses and apartment buildings, to large residential properties in exclusive neighbourhoods. Colm's service is located within a large terraced Georgian building in the city centre. According to Colm, the building has the space for placing "two in a room, there are 16 double rooms, and I think there are 6 single rooms in the building. The rooms are en-suite, with a shower, sink and toilet". From the front, the building is only distinguishable by the small plaque on the wall and blends well with the businesses located on either side. There is a security system inside the door which enables staff to let the person come in off the street before they are admitted through the next door, and inside the building. The reception area, which reminded me of a doctor's surgery with a glass hatch, is situated inside the hall, and this is an indication of the size of the service. The hall leads off in several directions, with staircases going both up and down and a corridor leading to another building that adjoins the main one. Although the whole building is

old, it is spacious, clean and appears welcoming and homely for a large service. As an another example, Jim's homeless service was a large detached private building, located within a residential village. Jim suggested that the neighbours in the adjoining property to his service were not completely happy "being on the other side of all those smelly homeless people". Jim's building was well maintained, and the interior was bright and spacious with plenty of pictures and paintings on the walls. The large building was redeveloped to include large shared spaces including the kitchen, three sitting rooms, which are sometimes used as key-working spaces.

In case cluster two I visited Emma, Ava, Michelle, Laura, Simon, Paula, Rita and Alice in their places of work. The day and residential disability services are structured around the level of support needed, and as such the contexts can vary considerably in size, architecture, and purpose. Three disability services are located within older more institutional settings, which have been adapted to suit contemporary care practice to some degree. For example, Alice is located in an old factory, that has been altered to include training rooms, however, "the roof has lots of leaks, and when it's raining you can have tiles falling down". Michelle, the CAMHS worker, is located in a section of a community health service. Michelle's service is located along one corridor of a detached building set off the road with a large parking area and a lawn with some trees. The corridor is away from the front entrance which is adorned with religious paintings and artefacts. The walls in Michelle's corridor are painted in two neutral tones, split by a painted rail, and the design resembles an old hospital or clinical setting. All the doors off the corridor are painted white, and the rooms have been recommissioned into a few purposeful work and therapeutic spaces. Michelle notes; "we have an art room, we have a group room and there is kitchen area, and that's it

really”. Within these spaces, Michelle does “a lot of work with young people to see how well they can use their creative side and how to express themselves and things like that. In the kitchen, we would do cooking with them which is an important life skill to learn”. In speaking to Michelle, her service appeared to function quite separately as if the service was both physically and professionally isolated from the rest of the building.

The day services for people with a disability are based on need so they can vary quite considerably in size, for example, Alice works with sixty-three adults with mild intellectual disability, and the majority of them are over fifty years of age. Alternatively, Laura works with nine service users with severe to profound learning disability between the ages of twenty-five and sixty. Because of the level of need, Laura feels like she is providing “nine services within one, so everybody here gets an individualised service because no one person is like the other here”. Unlike Alice’s large factory, Laura’s day service is set within a detached bungalow in a small residential village. The house is noticeable from the other houses on the street because of the ambulance parking space and the long ramp system, including a handrail, leading up the front door. There is limited parking which may cause difficulties for the many clinicians who use the service as a base for their outreach work with the service users. The many visiting professionals include; “occupational therapists, physios, speech and language therapist, the psychiatrist, the psychologists all come here to meet with the clients for their specific needs”. The rooms are multifunctional as service users are cared for individually in little pockets of activity throughout the house. Although there are only nine service users, they all have at least one-to-one care, and while I was there, I counted twenty people, on top of the extra wheelchairs,

hoists, walkers that were filling up the space, which ultimately, felt a little cramped. Laura said that community engagement is important for the service, so they are rarely all in at the same time. Also, there was a considerable noise level within the service, and at one point we moved out to a room at the back to continue the interview. This felt like a very busy and physical service for the workers employed here, but despite their workload, the walls were adorned with an array of colourful art projects and activity plans, and the space felt joyful.

Five of the six residential services for children and adults with a disability within this study are located within housing estates in the community, in line with legislation and policy (Department of Health and Children, 2004; Department of Health, 2010). I interviewed three of the participants (Simon, Paula and Rita) within their residential units. All three were detached houses in private residential housing estates, two bungalows and one dormer bungalow. All three houses provided care for people with an intellectual disability although both Simon and Rita provide some physical supports (a wheelchair and a hoist) for service users when needed. All three houses were very well maintained, with painted walls, matching wallpaper, carpets, and large bright kitchens. Paintings and photographs adorned the walls of the three services, and there was evidence of the residents throughout the house, not just within the individual bedrooms.

For the final cluster, children's residential care, I visited the houses of Adam and Eddie. Adam's service provides residential care for unaccompanied minors, and at the time of my visit, there were six children in the unit, four boys and two girls. The house was a large detached home built in the 1980s and looked a little dated from the outside. The service is located in a rural setting, on a busy road with no paths and the children

need to be driven to and from the house. There was a large lawn out the front with two permanent football nets. The house was decorated in varnished wood panelling, and the remaining walls were painted in rust tones. The rooms I saw were dark, and the furniture was more dated and sparse than the other services I visited. Alternately, when I visited Eddie's service, the house was located in a middle-class neighbourhood with predominantly detached two story homes. The house did not stand out from the neighbouring properties, apart from the large number of cars parked outside. The house was modern, with brightly painted rooms, there was a large kitchen and two sitting rooms downstairs, with bedrooms and a staff office upstairs. We sat in the 'good' sitting room, which Eddie said that since they did it up the kids hate and prefer to use the other room to hang out. There was a relaxed and homely atmosphere within the house.

Overall, the residential services within the homeless and addiction sectors were larger and catered for more residents than the residential services in either the disability sector or children's residential care. It is important to note that the accommodation is provided on a temporary basis in addiction or homeless services, until the person has received treatment or is provided with a more permanent and independent housing solution. The comments suggest that it is customary for buildings to become redeveloped and adjusted to suit the changing needs of the service user group and to adhere to the new directions of policy. The flexibility of social care services meets the requirements of new managerialism that are positive and service user friendly, but this flexibility and adaptiveness may be problematic, in that these practices may mask the underfunded, crumbling and possibly unsafe spaces that are

still in use. The discussion continues with the material culture of social care, that creates the experiences of living and working within these care contexts.

7.2.2 Residual Ideology in Social Care Spaces

Material culture is the bedrock of anthropological and archaeological theory (Hicks and Beaudry, 2010) and the term represents our material world, including the buildings, architecture, rooms, their purpose, how the space is decorated and all the objects in the space. The building, the photographs or paintings on the walls, the plates, cups and bowls, are all part of the service users experience of the service (Davies, Crook and Murray, 2015). Although the majority of the services have been redeveloped and decorated to suit the taste and physical requirements of the current service users and staff, one of the services has maintained some of the remnant artefacts from the material culture of the past. This service primarily provides education for children with a sensory disability, but as they stay in the centre from Monday to Friday, the service also provides a residential service.

One participant in this study, Una, works in the residential part of this service and she grew up close to the original building and remembers seeing “the girls go to the shops with the staff called ‘house mothers’ who wore white coats, they would be escorted in groups of say 6 or 10 to the shops, they were only allowed out on a Friday”. The service was established in the mid-1800s in a room within a convent, which was gradually expanded to include both a separate school and residential units on the grounds. Una described the current residential service as “like little bungalows all off the one corridor”, and there are four units “one unit of six, two units with eight girls,

twelve in another, all based on ages, not disability”. The service is still run by the religious order who founded it, and as a result, the building has grown in conjunction with the history of the Religious Order. Photographs on the walls have captured the material culture and significant events of the Order, from the Pope’s visit, the President’s visit, the opening of the new pool and some past and present pupils. The residential part of service includes more examples of the material culture of the current service users and staff, including personal items, photographs, laptops, toiletries, games and books. It became evident from the interviews that social care workers use specific spaces within or outside the building to create meaning and purposeful moments of care, for example, the car, the kitchen and the office.

7.3 Social Care Spaces for Purposeful Practice

There was an awareness from the participants that the spaces used for social care practice were not random, but purposeful (Gilligan, 1999).

“You could be working with a client for a month or two months, and you would bring them out for a coffee and things like that, you would learn more in that kind of setting” (Colm, homeless service).

When workers choose a ‘practice space’ they provide an insight into the spaces they spend time in, but also what they define as practice. The discussion on the built environment of care was able to provide examples that illustrated the diversity of care contexts. What is interesting here is that workers in different settings have a similar awareness to the function of a particular space for purposeful social care work. This is a key finding, that although the places and services are different, each worker shares an understanding of the potential to use a similar space for social care work. These

purposeful spaces are examples of where the direct care or in-direct care happens (Fulcher and Ainsworth, 2012). All participants provided examples of spaces they use for purposeful practice and the most common were driving someone in the car, drinking tea the kitchen, watching TV in the sitting room, and helping someone to go to the toilet. The other commonly used spaces included the office, where some workers did one-to-one work, and others completed paperwork. Auto-driven photo-elicitation supported the interviews by providing some examples of the participants' world of social care (Collier and Collier, 1986; Harper, 2002; Lapenta, 2011), and five participants shared their world here. Due to the sensitive and personal nature of the work due care was taken to ensure that there were no identifiable objects in the photographs published.

7.3.1 Different Rooms in the House

As many social care services provide residential care, the most common rooms identified are spaces within a house, and according to Ava, “there isn’t a room in the house that you don’t work in”. The most common response was the kitchen, described as the room “where all the action happens, all the good stuff” (Eddie). The kitchen has been described as the focus for activity (Sarkissian et al., 2009), relationship development (Coote, 2014), casual chats and a space of control (Byrne, 2014, 2016a.). Figure 7.1 is the first example of a photograph from social care spaces of practice, included in this study.



“It’s a big long table and the computer that the kids use is here as well in the same room, so even if they are not eating they are participating in this group moment which again at times when the houses are in real crisis or when there is a lot a behaviour or teens are stressed out and exhausted that you lose those kind of normal pleasantries but this is a daily thing, it’s either this lovely little intimate conversation or this big group moment with laughter and noise and people calling and talking, it’s fabulous, it’s a lovely moment actually. There is something kind of, I call it the last supper, something of kind of religious about it because it is a congregation, you never know who is going to be there someone from next door might pop in, the kids from the other house might wander over, do you know, looking for eggs and they plonk down” (Mary).

Figure 7.1 Kitchen Table in a Children’s Residential Centre (Photograph supplied by Mary).

Although Mary’s photograph shows the empty kitchen table, from her shared description, the room comes to life with people, noise, movement and engagement. From the photograph, we can see the wooden kitchen table and chairs, covered with a tablecloth, which matches the coloured tiles in the background. The mugs are still on the table, remnants from a shared conversation over a cup of tea. Although the computer is not visible in the image provided, Mary stated that the computer is kept here, so that staff can monitor the children’s online activity. In this way, the kitchen is also a space for surveillance (Foucault, 1977/1995), that is aimed at protecting the

young people while they are online but may be perceived by the young people as a form of control.

In Una's residential home (Figure 7.2) for girls with a sensory disability, the 'main kitchen' is a hive of activity, and in the photo, we can see the arm of one resident playing darts. Although there are small kitchens in the individual houses, all the young people go to the main kitchen to have meals together.



“The young ones are eating with the big ones and the big ones are eating with the young ones and it's lovely” (Una).

Figure 7.2 Kitchen Table in Residential Centre for Children with Sensory Disabilities (Photograph supplied by Una).

When I compare the aesthetics of the kitchen within both photographs, both spaces appear lived in and homely. Although the multiple tables in Una's kitchen may appear more institutional, this space was preferred by the girls. Byrne's (2014) photographs of the many kitchen tables in children's residential centres around Ireland, evoked discussion at the SCI Conference (2016) on the importance of creating a home and

how workers can find themselves betwixt and between their own beliefs and the policies of a regulated and risk focused approach to care (Smith, 2009). The kitchen is also the space where workers provide for the needs of service users who have “specific feeding requirements” (Laura). But as well as feeding, Laura stated the kitchen table is also used in her service as a space both the workers and services users like to do one-to-one work. Joan described her kitchen as a large bright space where the young people liked to hang out and sit with different staff. Emma believes that if the worker just sits down at the table, it creates an informal space to engage with others “you sit at the table, people will join you and it becomes a kind of hot spot”.

Interestingly, the bedroom was not a common place raised by the participants in this study as a space for purposeful practice. When I was training in the mid-1990s, lecturers warned us against being alone in the bedroom with the service users, especially in children’s residential care. The bedroom was mentioned as a purposeful space by staff in the disability sector. The next image Figure 7.3 is an example of a bedroom in Una’s disability service. Una discussed the importance of encouraging the girls to choose how the room was laid out and the colours used, although evident by the single colour and unified structure, choice is either limited, controlled and regulated (Foucault, 1977/1995), or not exercised by the girls. It is unusual for young people to share a bedroom in residential care (HIQA, 2013). However, Una stated that the young people do not live in the service on a permanent basis, and the close sleeping arrangements encouraged relationship development between the young people.



Figure 7.3 Shared Bedroom in Residential Centre for Children with Sensory Disabilities (Photograph supplied by Una).

Staff bedrooms often double up as the office within children’s residential centres, and as Eddie noted space can be an issue “so where the bed stops, my desk starts”. Eleven participants included the office as a purposeful social care practice space, and Figure 7.4 provides an example of Mary’s Office. Some participants described the fascination of the office for the young people, especially in residential care, and how the young people just loved being in there with the staff. The office was also noted as the main space for doing in-direct work (Fulcher and Ainsworth, 2012). “I spend a lot of time [in the office] because I am the social care leader in front of the computer, you know, rotas, payroll, every other kind of paperwork” (Ava). As a manager Ava’s workload is paper, rather than person focused, which directs her to manage both staff and service user timetables, to work with the case of the service users, rather than having time to spend with them. Foucault (1977/1995, p. 190) argued that viewing people as cases began in the hospitals and the medical disciplines and

“they marked a first stage in the ‘formalization’ of the individual within power relations”, which has become normalised practice in social care. Figure 7.4 shows Mary’s office in a children’s residential centre.



Figure 7.4 The Office (Photograph supplied by Mary).

The office for Mary became a space for meaningful moments where the young people “just pop in ” and sit spinning around on the office chair and just talk things through.

“I am having lovely practice moments in there at the moment, they are just thinking things through, they are trying to make sense of something that came up, they are processing with their key worker or with the staff or something is happening on duty... it is just a space where conversations are happening, loose, it's lovely” (Mary).

Laura and Ava also discussed the importance of the bathroom as a social care practice space in disability services (Carnaby and Cambridge, 2006). Both workers described the role of maintaining privacy and dignity while providing for the personal and intimate care needs of others. Social care workers also noted practice spaces outside the service, with the most popular being the car.

7.3.2 The Car

Nine participants in the study acknowledged the role of the car as a practice space and the rationales they provided include; freedom from routine (Milar, 2001; Bull, 2004), and the potential of the intimate and closed space of the care whilst driving a young person. The themes raised by participants reflect the discourse of Ferguson (2009, 2010) and Ross et al. (2009). The car is described as a listening space and a place to hear everything that is going on for the young people, within the “car conversations” (Ferguson, 2009, p. 280) with the benefit of no eye contact (Ferguson, 2010). Mary’s example highlights how the car provides freedom without the pressure to talk; it enables the worker to hear what is going on because the young person is contained.

“The car particularly has been a space always through my working life where practice happens and really significant practice moments have happened and I know that is something you will have heard and will hear from lots of practitioners because of the freedom that it creates to take the pressure off the intensity of the one to one. You are in a confined space so you can have these private conversations, but you are not focused on each other, they are not focused on you, you are driving so that it's a perfect space for practice” (Mary).

Based on the relationship between the social care worker, the car was a conduit for one-to-one communication and ‘car conversations’. Sarah’s example is also from

children's residential care, where she described how the car was used as an intervention to address a young person's behaviour in the house.

"I used to have a kid in another service, and he would crack up maybe once every six months, and he would go on a bender of crack-ups so he would go the whole hog, he would smoke dope, he would drink, he would run away. I would come in on the Monday, and I would purposely take him to school, and he knew this routine off by heart, and he would come down, and he would go Hiya, and he would get in the car, and we would be 20 minutes into the journey and he would say, Ok, you can start now. and I would say, Is there anything you want to tell me? and we would take it from there. And by the time we got to school that would be it done for him, it would be over then, no-one else needed to address it, he had done his sanction, it was over once we had had the journey in the car" (Sarah).

Collecting someone from an access visit, or when they are returning home late is also a way of expressing genuine care and affection for the young people (Rose et al., 2009). Social care workers can also be very vulnerable while they are driving in the car, for example, Mary's practice story in Figure 6.4. In the example provided by Liam, the car may be a safe, contained space for young people, but it is also a potentially dangerous place for the worker because they are doing social care work, while also concentrating on driving.

"We were coming back from a visit, and I asked [his] Mammy to ensure that she searched him, to check he doesn't have any glass or bottles that he could do harm with. But anyway, halfway down the road I looked over and there was a gun pointing at my head, and the other staff member in the car at the time wasn't watching what he was doing, he was looking out the window and the wee fella had seen this opportunity and pulled a gun from his trousers and he pointed it at my head. What are you going to do now? he says. I said I am going to do nothing, what can I do, I says I am driving the car, you have got the gun, sure if you do anything silly with that, we are all going to go over the ditch, and he looked at the ditch, and I pulled it off him, so I did" (Liam, disability service).

What turned out to be a toy gun demonstrated how quickly the situation can change and how the worker needs to keep calm and quickly assess, and react, whilst keeping everyone safe. This was a split second decision that could have ended in a number of

different scenarios, which also highlights the gravitas of social care work and the unpredictability of each encounter. The chapter continues with the last ordinary space used for purposeful practice; in places outside the service.

7.3.3 Out and About

The final space that workers use for purposeful practice includes all the places workers visit that are external to the service, for example, McDonalds, or a coffee shop, going for a walk in the park, going shopping, and sitting on a bench. External spaces were defined within the literature as part of normalised care (Gilbert, 2009), and a space for shared activities within direct relationship based work (Fulcher and Ainesworth, 2012; Smith et al., 2013). Getting out in the community was described as an important activity for workers in the disability services, for relationship development and as part of independent living skills training (Adolfsson, Sydner and Fjellström, 2010; Health Service Executive, 2012b).

Coffee shops were utilised by workers in outreach homeless services, especially if the client⁷³ was living in a hostel or bed and breakfast accommodation and it was difficult to meet. Both Bernie and Clare also stated that at times the coffee shop was not the most appropriate place, especially if they had to discuss personal issues. Jim described the importance of having lunch in a café as normalising the experience of doing one-to-one work. Also, Colm stated “staff have found that you get more out of [the resident] ... like just linking in with them and just bringing them out for a coffee or things like that”. It can be a challenge for workers in all services to

⁷³ Term used by several workers to describe service users in homeless settings.

pick an external space that is suitable and with limited risk, which will be of interest to the service user, however, as Jim advised, “just pick a space, and if they don't like it they will soon tell you”. As well as photographs, workers also described their setting through the use of a metaphor to describe how the specific setting influences their practice.

7.4 Metaphors for Social Care Contexts

Stake (2006, p. 6) stated that each case in a multiple case study should be studied to “learn about their situational uniqueness”. To find out what is distinct about a specific setting, workers were asked to use a metaphor to represent social care in their service. Evident from Chapter Six, many of the metaphors provided an insight into their *practice* with others in the setting. However, workers also demonstrated how the built environment can capture the lived experience of social care within metaphors that illustrate care contexts. The metaphors are presented here using the structure of the three case clusters.

7.4.1 Case Cluster One (Homeless and Addiction, Youth Crime Prevention)

The common context themes to arise from the researcher-led photo elicitation process from workers in homeless and addiction services were centred on supporting the service users to return home, find a new home, create a sense home and capture what it means to have a home and how to make a space feel like home.

- **Plant, Books, A Cup of Tea:** “Try to create a normal space” (Bernie).

- **A Home:** “A family settled in a community with enough supports around them, family or friends, like what I had growing up” (Clare).

The following quote by Joan encapsulates a lot of the themes about home raised by the participants. For Joan home is based in a community, where there is support and stability, and it is a permanent home where people can grow and experience all the rituals of life.

“I see a family settled in a community with enough supports around them, and I don’t mean us visiting, I mean community based supports, I mean that they have their family or friends around them, like what I had growing up that made my home a stable home, so that when I see a home I am talking about for the parents and for the children, a lot of the time I think a family struggles and is in crisis when they are in emergency accommodation for lots of reasons, when they are in their home they can actually take a breath, they can say this is where I am going to live now, and this is where I am going to bring up my family for the rest of my life, this is where my children are going to go to school from, this is where they are going to go to their debts from, this is where they are going to do all this kind of stuff, this is where they are going to bring their friends in. So, for the families that we are working with now the difference that we see when they move into their own room, in particular if it's a social house as opposed to private rented because there is still a level of uncertainty when they are in private rented because they are generally year-long leases whereas in a local authority home or in a social house it is theirs for life provided they pay their rent and don’t have antisocial behaviour effectively so when I see a home I see that, I see stability” (Joan).

Figure 7.5 is a visual reading inspired by all the metaphors relating to creating a home that feels natural, and to acknowledge the homeless crisis that workers in the homeless sector are dealing with when trying to source accommodation for their residents especially the single men and women. These two issues reflect a desire to capture ‘home’, to bring ‘home’ to people, either in a physical reality or in an emotional sense and feeling of being safe and secure in your permanent home.



Figure 7.5 **Visual Reading: Capturing and Creating ‘Home’ for Others**

7.4.2 Case Cluster Two (Disability and Adolescent Mental Health)

Disability and mental health services have moved away from large institutions, and congregated settings, towards a smaller community based approach to care (O'Connor, 1995; HSE, 2011, Linehan et al., 2014). As disability services have evolved from a medical and hospital context, the medical model was more dominant in services for people with a physical and/or intellectual disability (Cousins, 2007; Finnerty, 2009). The following metaphors were used to describe the contexts in cluster two; assistive technology and artefacts and objects from home belonging to specific service users.

- **Multi-sensory Toys to Make the Bedroom Homelier:** “Musical sensory toys that make noise and light up. Most of our kids’ bedrooms would have these as this is what they play with. We also have normal curtains for a kids’ bedroom to make it more homely” (Paula).
- **A Personal Photograph:** “A picture of somebody, something that it is personal” (Liam).
- **A Big Clock:** “Time is a big issue, time to get anything done, you are under pressure. And time to file, the filing has become a huge issue” (Ava).
- **A mobile phone or a laptop:** “Technology offers our community a wonderful new world and method of communication” (Una).
- **Open Windows:** “A safe space, kind of letting what you let out in here out the window” (Samantha).

Figure 7.6 reflects the use of technology in disability services, which also include objects representing the material culture of home (clothes on the horse drying in the house) within residential disability services (Woodward, 2007). The service user is not paying attention to staff because she is playing with her tablet, using assistive technology which has enhanced her ability to choose and effectively communicate her choices (Ravneberg and Söderström, 2017). Una also noted the importance of technology to enable the service users in her unit to keep in touch with family. Now the young people can use Skype to contact their parents during the week for free, and

they can speak to them using sign language over the computer screen. For Una, technology has enabled the young people to engage with others independently without needing to hear or speak.



Figure 7.6 Technology Makes my Home Work (Drawing by Denise Lyons)

Figure 7.6 encapsulates two of the themes raised in this cluster, the importance of creating a home away from home, and the importance of technology for people with a disability. The final cluster children's residential care also raised the theme of making the space feel as homely as possible for the young people living there.

7.4.3 Case Cluster Three (Children's Residential Care)

Children's residential care also evolved from the large institutions under the administration of the Catholic Church towards community based services with an average of four children per house (O'Connor, 1995; Raftery and O'Sullivan, 1999; McHugh and Meenan, 2013). The main context themes to emerge from the photo elicitation process was the need to create a sense of home, within a service that is bound by the remnants of institutionalisation and regulation (Brown and Scott, 2010). The main theme reflected the workers' need to create a sense of home for the young people living in care.

- **Objects from a Real House:** "The normal and casual stuff of real life house situations. A hair straightener and a bottle of nail varnish remover that's left open" (Eddie).
- **Little Things that Represent Home:** "I think it's important that you have little things that makes it their home, so pictures, memories" (Emma).

Figure 7.7 illustrates these everyday objects that are placed on the window sill of a girl's bedroom in Eddie's residential unit. The objects are personal and reflect a sense of ownership of the room and a sense of permanence, of safety in being able to leave personal items lying around. Workers in every setting appeared aware of the importance of personal objects for their service users, especially in residential services. Ava, (disability service) commented on the importance of making sure she had extra batteries for the Wii, or her service user is "likely to create havoc in the house". The participants could recall all the different personal items that were precious, or just practical and used by their service users. In Figure 7.7, the items are the functional and practical products commonly found in a girl's bedroom.



Figure 7.7 The Window Sill in a Girl's Room (Source: Pencil drawing by Denise Lyons)

The final section of this chapter focuses on the main theme that was raised by the majority of workers in this study, the desire to create a sense of home. Interestingly, this was experienced by workers in services that provided temporary accommodation, and day services. Irrespective of the duration of the time they had together, workers were conscious that the space should feel as homely and welcoming as possible.

7.5 Creating a Sense of Home

Evident from recurring statements within the analysis on spaces and places of care, and the metaphors and symbols provided for social care settings, ‘creating a home’ is an important theme of social care work, which reflects the national standards (Department of Health and Children, 2004; HIQA, 2008; HIQA, 2013). It is presented here as one of the unifying themes or shared enterprises, irrespective of the context of care, and it is the ambition of all workers to create an experience of home within their service. Home is a value-laden concept, which is experienced both physically and psychologically (Ferrari et al., 2006). We all have different ideas of what a home is, as Paula comments “, it’s a home, this is what would happen in a normal home”, but what is a normal home? and students may not get the opportunity to explore this complex issue (Hutchison, 2004; Burton, 2015) within their college learning environment before they bring their idea of ‘a normal home’ to the workplace.

Although there is no mention of the development of homemaking skills within CORU’s (2017b) standards of proficiency, Domain 5 (point 11) states that workers should “be able to analyse activity and adapt environments to enhance participation and engagement in meaningful life experiences”. Creating a home-like experience is presented here as a shared enterprise (Wenger, 1998) of social care practice, and the emphasis here may inform the regulator of the importance of the contexts of care to the workers’ experience of practice, which may exceed the standards of proficiency (CORU, 2017b). The inclusion of this standard will support workers by acknowledging the importance of adapting environments to become more welcoming and homely for the well-being of those who live and work there.

Byrne (2016) described the tension workers experienced to reduce the institutionalisation of the service, and this was evident in subtle ways. For example, Jim wanted to have an open fire in the sitting room, but it was not permitted because of fire regulations. Mary, Amanda and Kate could remember working in institutional settings in their early years, and their current challenge was to resist regulations that made the service 'feel' more institutional. Uniquely the place of work is also considered by some workers as their other home, where they bring elements of "what you would do at home" into the work environment. For example, Jim stated that he leaves a spare pair of slippers in work, "look I wear slippers at home, and this is my other home" (Jim). However, Colm notes the importance of knowing the difference between feeling at home within the work environment and being respectful that "this is their home, we only work here". The participants in the study were very aware of the service user's ownership of the space, especially in residential disability services and of the importance of describing their service user's original family residence as their 'home' when appropriate.

7.6 Conclusion

Interviewing social care workers within their place of work gave me an added insight into their experience of practice, because the building, the context of care is also an important theme in understanding social care work. The contexts of care were as varied as the practices experienced within the walls. Workers in case cluster one, homeless and addiction services tended to work in large residential centres on private

complexes that included spaces for treatment and living. Workers in case cluster two (the disability and mental health group) worked in a variety of settings including ordinary houses in the community, modified services in factories, or treatment sessions in hospital type environments. There was more consistency in the buildings used for children's residential care, which were all residential properties predominantly in housing estates in the community. The main finding from the contexts of care is that irrespective of the building, social care workers use similar spaces for purposeful social care work including the kitchen and the car. Also, workers shared a desire to make their service feel like home, both in the way they organised the space with the material culture of home, but also in the way they wanted the service users to be treated within the space. The thesis concludes in Chapter Eight with a summary of the main findings and data analysis within the three themes of social care; practice, identity and context.

Chapter Eight Conclusion and Implications

8.1 Introduction

This study originally aimed to discover the gap between social care education and practice in preparation for approval by the Social Care Registration Board. This issue is still relevant; however, the direction of the research process was shifted to address the more pressing question of what constitutes social care practice in Ireland. This study captured the ‘techniques of representations’ through the shared and indigenous practices of social care workers through a holistic multiple case study on their understanding of practice, from the inside out (Foucault, 1977/1995, p. 299; Wenger, 1998; Yin, 2009). This concluding chapter presents a summary of the key findings and my answer to the question ‘what is social care in Ireland?’.

I argue that social care work is complex, and based on the interrelatedness of the worker, the context and their relational practice with others. However, social care is under threat from neoliberal policies, a normalisation of the mechanisms of new managerialism and a disconnect between education and practice. This concluding chapter begins with main findings from the workers regarding how a social care identity is developed from the workers’ stories and examples of practice, and the diverse contexts of care which provided a breath of discussion on the workers’ experiences of social care in Ireland.

8.2 Social Care is in a Liminal Phase

Social care is described as an ‘emerging profession’ (Hutchinson, 2017, p.2), with the term ‘emerging’ used to describe a process of “becoming established” (Stevenson, 2010, p. 573) by moving from one identity to another. Social care will have officially ‘arrived’ when the Registration Board can identify “what is or what is not social care work” (Hutchinson, 2017, p.3), and in line with previous consultation procedures, everyone involved in social care will be invited to contribute to the decision making process. The respondents initially argued that they could not define social care, which may seem problematic from an official or disciplinary point of view. However, their individual cases, stories and elaborations painted a clear picture, on one level, of what it is like for them to be engaged in social care practice. The study also acknowledged that social care work – and the experience thereof - is not definable in advance; it's one defining feature is the intrinsically mobile nature of human relations, and of the social care workers’ ability to learn, adapt and relate. The specific ways that these workers experience social care work are summarised in the forthcoming sections.

8.3 Workers and their Professional Identities

Seven males and nineteen females participated in the study, reflecting the high numbers of females in care roles and the historical remnants of the cult of domesticity in Irish society, and societal attitudes to care as women’s work (Cott, 1977; Fisher and Tronto, 1990). The number of male participants is high, considering most workers in the study are on predominantly female teams. There was a perception amongst some

workers in the study that males are utilised for their brawn in handling difficult service users (O'Toole, 2013). Again, this is an enactment of normalised forms of power that undermines the potential of both genders in relationship based practice (Smith, 2009). Workers also stated they felt privileged and humbled to be in their position as a social care worker, and despite many people not choosing it initially, were still delighted to be there. The majority of social care workers in this study identified having a desire to help others, which stemmed from observing the altruism of others in their formative years, or being actively encouraged by an influential adult (Lynch, 2009; Jenkins, 2014). The findings did not correspond with the literature that suggests many social care workers are attracted to the caring profession because of their own similar experiences (Ricks, 1993; Lyons, 2016).

Beginning with their education, most participants stated that their identity as a social care worker began during their education. Progress was limited in the classroom, but some workers had lecturers that were trained in social care, and they were deemed as speaking the 'truth' about practice. The most common educational setting for identity development was the practice placement, especially if the worker was supervised by a qualified social care worker. The findings are concomitant with the work of Lancaster (2014), where their placement experiences varied in quality and relevance. Experience on the floor doing direct social care work with others was defined as a rite of passage for any worker claiming the identity of a social care worker. Time with others was viewed as the most important way to develop competence as a worker and transition from the inexperienced newcomer to the status of competent and present old-timer (Turner, 1969; Wenger, 1998; Garfat and Fulcher, 2011). Although

workers also noted that ageing also affected direct practice, as the work was tiring and challenging, this issue was missing from the literature consulted for this study.

Social care work was defined as requiring multiple roles, and the workers within the study claimed several identities as embodied within their role as a social care worker (Reynolds and Herman-Kinney, 2003; Schachter, 2015). Although some workers were uncomfortable with the term helper, being a support to others and helping them to meet their needs and feel safe was identified as the main role of social care. The other roles claimed include; whistle-blower, team-member, key-worker, advocate and observer. The norms or regimes of competence (Wenger, 1998) were solidified (Schachter, 2015) through performance (Butler, 2005) into their identity as a social care worker, evident from their ability to gain employment by performing the role of social care worker while on placement. Scholes, (2013) argues that when people are working in a vocational occupational, their work is aligned to their moral compass and provides them with a sense of meaning, and the findings supported this claim. Workers in this study were affected by the diversification of title within services, especially those who have witnessed the introduction of the lower scale 'social care assistant' to replace social care positions. Although 'social care worker' is the title protected by the Health and Social Care Professionals Act 2005, eight workers had an alternative title, with 'project worker' being the most common. CORU aims to circumvent the practice of defining social care by the work title alone, by establishing a criteria to distinguish workers engaged in social care work (Hutchinson, 2017). The hope is that this step will discourage services from excluding the title 'social care worker', for work that is clearly within the social care remit.

8.4 Social Care Practice: Relational and Embodied

The relationship emerged as the most significant shared enterprise of social care work, because of their specialised use of the relationship they have with the service users, irrespective of the context. This is not the view of relationships as a tool (CORU, 2017a), but as “the centre of it all” (Ormond, 2014, p. 252). Learning is central to this process (Lave and Wenger, 1991) and the knowledge gained is used to understand likes and dislikes; interpret communication cues; meet needs quickly and effectively; provide support appropriately, and to be an advocate by communicating accurate information to others. Literature from relational child and youth care in Canada is very relevant to the social care work relationship in Ireland, irrespective of the setting (Maier, 1992; Kreuger, 2004; Garfat and Fulcher, 2011; Garfat and Charles, 2012; Charles and Garfat, 2013; Fewster, 2013). Also, social pedagogy, through the trinity of head, heart and hands, provides a workable framework to support the findings that social care is embodied, thus requiring a physical, cognitive and emotional engagement (Smith, 2009, 2012; Cameron and Moss, 2011; Moore, Jakhara, Bowie and Marriott, 2014).

The following visual reading is my interpretation of the collective practice stories and descriptions that workers’ shared on their experience of being in a meaningful social care relationship. I have used the multiple examples from the workers’ testimonials to create one meaningful moment, that may enhance our understanding. The drawing Figure 8.1 on the following page, aims to portray the uniqueness of the relationship that is integral to social care and was shared by the respondents in this study.



Figure 8.1 Visual Reading: The Social Care Relationship (Source: Pencil drawing by Denise Lyons).

In the visual reading Figure 8.1, the ‘connection lines’ are visible between the worker and service user. The image represents the genuine connection between both the service user and the worker, which is based on feelings of safety and trust (Smith, 2009; Smith et al., 2013). The worker is holding a book to depict their role as a learner by actively listening and responding when appropriate (Lyons and Howard, 2014). The worker is relaxed and has settled in to spend time engaged in a conversation with the service user. The service user here is turned towards the worker and is actively engaged in the chat. She feels safe because she has positioned herself higher than the worker and both are comfortable with their potential power in the relationship. The workers in this study described this relationship as; something to build on, to form, and sometimes repair, as good, special, concrete and really there, real, amazing, lovely, as needing focus and trust, as being a difficult thing to establish, as needing time, and

experienced as personal with a sense of ownership, as well as being professional. The relationship was described by participants, through their practice stories and the photo elicited discussion as being present, hanging-in, as creating and paying attention to meaning moments (Kreuger, 2004; Garfat and Fulcher, 2011). They also stressed the importance of learning from mistakes and being prepared to act at a moments notice. Encouraging and supporting others to move on was also raised, especially from workers in children's residential care and homeless and addiction services.

The practice stories provide examples of the relationship as the core of the workers' practice, in line with the many scholarly discourses in Chapter Three (Kennefick, 2006; Lyons, 2009, 2013; Cameron and Moss, 2011; Brennan, 2012; Charles and Garfat, 2013; Behan, 2014; Howard and Lyons, 2014; Mulville, 2014). Workers noted experiences where behavioural approaches were normalised in practice and presented to the worker as a more effective way to work. The concern here, given the historically recent entrenching of austerity and new managerialist principles, is that without a strong relationship-based identity, social care workers in Ireland will lose confidence in their relationship based practice (Brown, 2017) and their knowledge gained from the 'inside out' (Fewster, 2013). The ideal situation is a collaboration between social care work and the perspectives from professionals working from the outside in, which many workers in this study are currently experiencing.

This study also suggests that social care work is embodied involving the head, heart and hands (Petrie, Boddy, Cameron, Wigfall and Simon, 2006; Brühlmeier, 2010; Brown, 2014). Workers are cognitively engaged in social care practice, evident through their ability to read another person and respond quickly; their opportunistic use of shared moments for relationship development, and their ability to transform

ordinary places into practice spaces. Social care workers are also emotionally involved in their work. Social care exists in a liminal space between being professional and personal (Turner, 1969; Doyle and Lalor, 2013), which can evoke a myriad of emotional responses for both the worker and the service user. Managing these emotions is challenging for the worker, which demands a level of self-awareness and an ability to engage in ongoing self-reflection (Buggle, 2014). The social care workers' body is also involved in their practice through the hands-on activities of care and the physical closeness required for touch and care. The participants understanding of practice as involving the (being) heart, (thinking) head and (doing) hands, is in line with contemporary theories of practice from Ireland (Digney and Smart⁷⁴, 2014; Brown, 2017), Scotland (Smith, 2009, 2012) and Canada (Maier, 1992; Garfat, 2008 and 2012; Garfat and Charles, 2012).

8.5 Social Care Contexts: The Relevance of Practice Spaces

The cultural context or figured worlds of the different social care services have shaped the practice and identity of workers in this study (Holland et al., 1998). The findings are consistent with the literature in Chapter Three, which suggests that workers gain a 'regime of competence' (Wenger, 1998) through the situated learning with the specific context of care (Lave, 1988; Lave and Wenger, 1991). Social care workers in specific settings are engaged in specialised tasks and ways of working that relate to the needs of the service users in the setting, for example learning how to do a Holistic Needs Assessment in homeless services, or how to perform personal care with dignity in

⁷⁴ Maxwell Smart is the co-author of the chapter and is not from Ireland.

disability services. Interestingly, workers spoke more about their use of spaces in their relational work with others, from ordinary places into meaningful spaces (Lefebvre, 1991; Tuan, 2012). The situated learning lens, through the framework of joint enterprise, shared repertoire, and mutual engagement also mirrored the findings (Lave and Wenger, 1991; Wenger, 1998). The workers in this study are involved in the joint enterprise of accountable practices and learned responses. They are mutually engaged with the service users through doing things together and sharing life spaces, experiences, history, tools and practice stories with their colleagues as a way of learning about practice. The relationship is supported and enhanced through the meanings and values attached to the relational spaces of practice within the social care setting (Milligan and Wiles, 2010). The discussion on social care spaces was supported through the photo elicitation process, and the most common spaces included the car, the kitchen table and the different spaces outside the service, for example, the coffee shop. A significant finding illustrated the important role of ‘car conversations’ (Ferguson, 2009) in social care practice.

8.6 Overview of Shared and Indigenous Enterprises

Social care work is situated and influenced by the needs of the service users and the indigenous practices of the service. As discussed the relationship emerged as the most significant shared enterprise, however that are other common roles and tasks, and ways of working and being that together represent social care work as more than “a collective of practices on a continuum” (Hutchinson, 2017, p. 1).

- Report writing; in some way and often using records that are indigenous to the setting, workers are involved in recording their experiences with others. The level of documentation, influenced by the regulatory mechanisms of new managerialism was experienced by all as cumbersome and taking the worker away from doing direct care with others (Fulcher and Ainesworth, 2012).
- Key-working: in all sectors, there is an acknowledgement of the importance of assigning a link person on the staff team with special responsibility for a service user. This is designed to encourage relationship development and consistency, so that one worker will have a good relationship with all the professionals connected with this person's care, and have an in-depth understanding of the person's needs.
- Routine Tasks or Chores: All social care workers are engaged in a variety of daily tasks to a greater or lesser extent, which may include cooking, cleaning, laundry, grocery shopping and house maintenance.
- Purposeful Use of Ordinary Spaces: social care workers in all settings described the practice of using a specific space for purposeful practice, a spin in the car, lunch in a coffee shop, or a walk in the park.

8.7 Dominant Ideologies Influencing Social Care Work

Chapter Two described the rise of the neoliberal agenda in Ireland and the impact of this regime on social care practice. After the recession of the 1970s and 1980s and the political rejection of Keynesian economics (Harvey, 2005), the 'new right' ideology of Margaret Thatcher and Ronald Regan gained momentum (Murphy and Dukelow,

2016). Ireland was ‘politically delayed’ because of the embedded relationship between the State and the Church (Dukelow, 2011; Lynch, 2012; Murphy and Dukelow, 2016). However, collaborations between the three social partners; government, employers and unions moved Ireland’s economic policy further towards the neo-corporatist model (Murphy and Dukelow, 2016). In the recession of 2008, Unions again sided with the corporate interests and disadvantaged workers further (Allen, 2000). This study shows that social care was significantly altered from the three characteristics of neoliberalism; privatisation, consumerisation and new managerialism (Lynch, 2012; Lynch, Grummell and Devine, 2012). In particular, the normalisation of the neoliberal technologies of rational/scientific accountability, the individualisation and consumerisation of service users, and the role of self-surveillance in the regulation of social care (Edwards, 2017).

The marketisation (Rogowski, 2015) of social care services was pursued, and tenders were offered to private companies for the care of Ireland’s most vulnerable. The welfare retrenchment of austerity was detrimental to social care, as funding was reduced, services were limited or closed down and forced wage cuts became standard practice. Testimonials from respondents clearly demonstrate that economic policies have negatively affected the provision of care to service users across all settings. There is evidence that some mechanisms of power have influenced the development of social care workers as neoliberal subjects who are reinforcing the mechanisms of control through scientific/rational outcomes which can be measured and valued (Foucault, 1977/1995). Within this system, workers and service users are controlled. Although Ireland was declared as moving out of the recession in 2016 (Roche, O’Connell and

Prothero, 2017), workers in the homeless sector described the housing crisis as the single most important issue still affecting their service (Focus Ireland, 2017).

The recruitment moratorium and the privatisation of care services has detrimentally changed the landscape of social care. Workers unable to gain full-time employment applied to private agencies, who were the only employers of social care workers at that time. Privatisation of care was viewed as a flexible and cheap solution to the problems in the public sector (Cantwell and Power, 2016). Social care workers argued that the use of agency staff was not best practice, especially for people with severe intellectual disabilities, those with attachment issues, and those requiring physical care (O'Connor, 2009; Keohane and Kuhling, 2014; Cantwell and Power, 2016). Using agency workers for clients on the autistic spectrum, who can become acutely distressed with change, is evidence that the Government has prioritised cost over care (Keogh, 2011). Privatisation in the whole was viewed by the workers in this study as negative and undercutting the statutory services and causing one worker, Ava to become so disillusioned, she left her job. Pay and conditions for social care workers are still lower than before the 2008 recession, with workers still unable to acquire full-time positions and in receipt of lower wages and conditions (Ferguson and Lavalette, 2014; Baines and Cunningham, 2015). The scarcity of 'good' social care positions has reduced the movement of workers within the sector, as staff are fearful of leaving their permanent post. Mary (children's residential care) argued that people may be staying on for longer than they should. Also, workers are accepting poor conditions including a culture that deems it acceptable that social care workers are assaulted by service users in work (Keogh and Byrne, 2016).

The emphasis away from the relationship and towards tacit outcomes is evidence of new managerialism (Biesta, 2004; Mulkeen, 2016) causing a deprofessionalisation of social care (Hughes, 2006; Svensson, 2006; Finnerty, 2012). Deprofessionalisation is experienced as a loss of autonomy, less professional recognition, and/or payment and lowered status (Hoyle and Wallace, 2005; Evans, 2008; Finnerty, 2012). Some workers in the study described their deprofessionalisation as following the psychological/behavioural plans drawn up by the behaviour support team, without consultation. Workers expressed concern that their opinions were not valued by the multidisciplinary team or the predominantly medical management hierarchy, also evidence of the normalisation of the medical expert (Edwards, 2017; Edwards and Fernández, 2017). This may also be evidence of a gender bias which views the opinions of female social care workers as less valuable. These findings are concerning because social care workers, through the relationship, are best positioned to advocate on the accurate needs and wishes of the service users. Increased regulation was another characteristic of new managerialism that workers discussed, especially the frequent and publically reported inspections by HIQA. Although workers fully acknowledged the importance of inspection for the safety of service users, the main criticism was the increased level of paperwork which took workers away from the service users (Molloy, 2014). This study also argues that consumerism, particularly the policy of 'Direct Payments' (Department of Health, 2010) and individualisation, adds to the complexity of service provision. Participants provided examples of service users having a reduced choice or fewer activities because their family had withheld the service user's money, thus reducing them to 'flawed consumers' (Bauman, 1998).

Finally, the medical model and approach to care in social care services is also viewed as a dominant ideological influence on practice. Workers in this study claimed lower prestige and less professional recognition in services with a predominantly medical model. Irrespective of the further qualifications obtained, some workers in disability and mental health settings described how their voice was silenced and felt equally disempowered as those in their care. The concluding chapter continues with a summary of my research journey and the limitations of this study.

8.8 Summary of the Research Journey and Limitations of the Study

The twenty-six participants in this study are representative of the diversity within the membership of Social Care Ireland. The 25 settings included in this study are representative of the main employment areas for social care workers; the disability sector; children's residential care and the homeless sector, as evidenced from the major studies and literature on the sector (Share and Lalor, 2009; Lalor and Share, 2013; Keogh and Byrne, 2016; Social Care Ireland, 2017). I need to acknowledge, however, that social care workers may be employed in a variety of other settings which will only become known after the register opens.

The approach to case study research in this study was influenced by Yin (2009), Stake (1995, 2006, 2010) and Merriam (1997, 2009). The propositions, identified from the literature review raised questions which related to the three themes of this study; practice, identity and context. These statements provided a guide for the study, and the findings that emerged complemented the propositions on practice, identity and context.

- Propositions on Practice: The findings suggest that social care work is relational which involves the use of self (heart), requires a hands on approach through the indigenous tasks of manual handling and the shared enterprises of report writing, and the human response of touch to meet the care needs of others (hands). The findings also show that practice is informed by the cognitive engagement of workers in the day to day decision making of their role (head) and the dominant and residual ideologies especially neoliberalism and its administrative structure new managerialism.
- Propositions on identity: The findings show that identity is diluted by the use of multiple titles in practice and education and that the workers' professional identity is significantly defined by the practice setting. Workers' identity was especially evident within stories of practice and through the description of the relationship they share with service users.
- Propositions on Context: The twenty-five cases are evidence that social care has expanded into a variety of services, which are developed to meet the diverse needs of service users. The findings suggest that social care workers learn about practice through their participation with others in the setting, and that context is relevant to practice. Workers provided examples through the metaphors they shared of how material culture is relevant to their experience of practice. Workers also provided concrete examples of how they use definable practice spaces within each setting.

However, the key finding in this study of experiences of direct practice being a rite of passage for social care did not emerge in the literature.

Doing research on the lived experience of social care work is challenging. Firstly, the workers had difficulty describing what social care work was for them, and because the work is embodied, it feels personal, instinctual, and common sense, and thus difficult to verbalise and describe. It was a challenge for me in supporting the participants to unpack their personal experiences of practice. Within case study research, observations and journals are deemed to be effective methods to gather rich data on a case (Stake, 1995; Merriam, 1997). However, based on my experience of being a social care worker, all the meaningful moments of social care practice occur when engaged in relational work, which is a delicate and intricate space. Even if permission was granted for direct observations (Graham, 2011), I still would not choose observation as a methodological tool for this project. Based my understanding of practice, the presence of another person, especially a researcher, would completely change the moments for all parties. I also considered encouraging the participants to keep a reflective journal, but based on the high level of recording expected from workers in all services (Molloy, 2014), I felt the journal would increase their workload exponentially.

Although the photo elicitation process, especially the researcher-led question did provide an array of in-depth responses not previously encountered by direct questions, I still consider this a limitation of the study. With more time I could consider alternative ways to discover the lived experience of practice that would not impact on the day-to-day life of the service user, would not disturb the authenticity of the relationship and meaningful moments of practice, and would not increase the workload of the already overworked social care worker. Social care workers were asked to talk about their own journey into care, but the responses did not reflect the

literature (Ricks, 1993; Lyons, 2016). However, one of the limitations of doing interviews is that the interviewee is less likely to share personal information when the interviewer can see them, face-to-face (Archer, 1980; Spears and Lea, 1994; Opdenakker, 2006).

Creating drawings of the figured world of practice was a very rewarding experience for me in this thesis. As discussed, the drawings provided a moment of pause to focus on an imagined world of practice that I had visualised in my head and then actualised into a drawing. The drawings are my visual interpretations of the spoken word and are thus one step removed from the participant. Nevertheless, they serve an important role, to emphasise the text, the experiences of the participants, by providing the reader with an image which will help them to remember the context related to the image (Collier, 1957; Collier and Collier, 1986; Jenkins, Woodward and Winter, 2008). The drawings also enabled me to make the product of the research, the final thesis, a reflexive piece which emphasises the collaborative nature of the research process. The final section of this concluding chapter is on thoughts for the future.

8.9 Conceptual Contributions and Policy Implications

This research constitutes the first study of social care across multiple settings in the Republic of Ireland, viewed through a sociopolitical, sociocultural and social pedagogical lens, which provides evidence of the importance of the relationship as one of the main shared enterprises uniting the profession. The following excerpts from King (2014) demonstrates how people are aware, even from a young age, when the

relationship feels safe, genuine and significant (King, 2014, p. 39 - 40). The excerpt begins with King's induction into the residential centre and his first encounter with his new key worker 'Maurice'.

"Trust, or lack of it sometimes, became a key element in my experience of the care system. However, one person caught my attention. I recall seeing a middle-aged man playing with a child in the café. For some reason, I immediately felt safe around this person as I had seen him previously and noticed how he appeared to be a loving and caring person. To my advantage, I was informed this man would be my key-worker".

"Although we may have only been together for a relatively short period of time (5 months) he, Maurice made a massive impression on my life. During my time in care, he was always there to offer advice, and I knew I could trust him completely. He earned my trust because of what my observations of him told me. My trust in him grew because he always stood up and advocated for me. I remember him taking time with me to go for walks into town just to spend time with me and discuss events in my life".

King (2014, p. 47) concluded his chapter with the following advice for social care workers of the future "take the time to get to know the person in your care".

This study makes an important contribution to informing and contesting the official principles of professional practice in social care in Ireland, by placing the social care relationship at the core. In her PhD research with twenty-six social care workers in children's residential care, Brown (2017) described a shift away from relational-practice, based on the workers' response to a culture of fear through new managerialism "where "objective' and 'emotionally detached' practice is viewed as synonymous with efficiency and effectiveness" [original emphasis] (Brown, 2017, p. 6). Predicated on the testimonials of the respondents, and the corresponding literature within Ireland, Scotland and Canada, this study recommends that policymakers, educators and workers themselves view the relationship as central to practice as the first step to reduce emotionally detached practice (Brown, 2017). As the view of the

relationship within CORU's 'standards of proficiency' is limited, social care needs a theoretical frame underpinning the knowledge base of social care that presents the relationship as core and central to practice. Presenting social care as a trinity, through a social pedagogical/child and youth care lens, provides such a frame.

In a time of increased marketisation of care, there is a real threat that people in social care settings will not have the support they need because the relationship is not valued or resourced adequately. Supporting workers to support others may be a cost saving initiative in the long term. It takes time to develop this relationship, and the time it takes to share moments and experiences needs to be valued by everyone involved in social care; the educators, the workers, the managers, and the government. This study also urges policymakers to revisit their strategy of using agency workers in social care services. Social care workers need to be permanent members of staff to enable the service users to learn to trust them and to rely on them being there when they are ready to be supported. Having agency staff and people on zero hour contracts is non-productive and undermines social care work. It is also completely detrimental for service users who need to know the people who provide care and support for them. The concern here is that the pendulum has swung too far in the opposite direction, away from care and being personal in the relationship, towards a fixation on being risk-averse. Social care workers in line with contemporary discourse (Smith, 2009; Digney and Smart, 2014; Ormond, 2014; Byrne, 2016; White, 2016) are asking for a shift towards care and love over risk, where workers can be more personal and present in their practice with others (Lyons, 2013).

Social care education plays a pivotal role in the development of the identity of the worker, and according to the workers in this study the relevance of both the

undergraduate and in-house training workers have received, is at best, limited. Social care education is facing its greatest challenge since the Criteria for Education and Training Programmes was launched in May 2017 (CORU, 2017a). This study encourages educators to seize this opportunity and rise above the threshold standards required by the registration board (CORU, 2017b). Social care education is under threat from new managerialism where economic policies are valued over quality and fit for purpose programme development. The origin of social care education, the Kilkenny child care course ran from 1971 until 1981, and training in relational work was core to the programme design, which centred around self-awareness (Lyons, 2013). The early social care programmes also had an understanding of the importance of teaching people how to be with others, for example, the personal development module designed by Patricia Kennefick in Cork IT (Kennefick, 2006) and the personal development course in Carlow College. However, this training is expensive unless you have small numbers of students in each class. Since 2006 the average number of students in social care courses, apart from DIT, has doubled (Courtney, 2012). Social care education needs to recognise the importance of the relationship for social care practice and centre the education programme around training workers to form relationships, to support, listen, observe and learn how to meet their needs effectively and efficiently, and to advocate these needs accurately to others.

Workers also recommend that social care education is provided by educators with experience of practice. These workers as educators will help in unifying the future social care workforce under a clear relationship-based understanding of social care work. In agreement with the registration process, it is important to ensure that students are surrounded by discourses of workers from their own profession, both within the

college and while on placement. This will become an influential force in the knowledge base of social care and contribute to their identity formation in the future.

8.10 The Future - Statutory Registration and the Social Care Relationship

Ultimately, the knowledge gained from this research aimed to enhance the education of new graduates towards '*fitness to practise*' and to inform and contest Statutory Registration in an ongoing way. The inspiration for this research lies in the difficulty educators, workers and managers face in defining and ultimately understanding social care. This difficulty is understandable if the field of social care in Ireland has not yet developed "a coherent and well-recognised theoretical and philosophical basis" (Högström, Nilsson, Hallstedt and Share, 2013, p.19; Hutchinson, 2017). This study aimed to capture the experiences of social care workers in a variety of different settings during this liminal phase in the development of this profession, before the register opens. Statutory registration will regulate and alter social care programmes, will define social care work by classifying what the experience of being engaged in social care work is for all workers in any service. It is unknown how social care services will react to the criteria defined by the Social Care Registration Board as workers are required to register. There is evidence that the standards of proficiency, already defining social care practice are underpinned by a medical discourse, and they do not put the relationship at the centre of all activity or acknowledge the purposeful use of practice spaces for meaningful work.

Also, the standards of proficiency underestimate the situatedness of social care and the role of the context on the indigenous knowledges and practices of the work.

There is a value in considering the purposeful use of practice spaces and acknowledging the pursuit of all workers in establishing a welcoming and homely environment in order to enhance the service users' experience of care and rights based practice. Also, the standards inadequately reflect the multiple claimed and performed identities of social care and how the self of the worker, their motivations, life experiences, ability to use humour and touch to make a genuine connection with another person, are all valid experiences that workers have included here.

At the time of writing this thesis, social care educators were preparing to align their programmes with the 'Criteria for Education and Training Boards' (CORU, 2017a) and writing their application for approval by CORU. CORU and the Social Care Registration Board were also busy with the task of defining the principles of social care practice through the shared and indigenous enterprises, and the holistic embodiment of social care, which will help them to distinguish those who are engaged in social care work from those who are not. This study can make a considerable contribution to inform and contest the multiple representations of social care. In finishing this PhD, I hope to do my part and "stand up for us all" (Paula), and represent the workers who contributed so passionately to this study, and defined social care work in Ireland as; practice, identity and context drawn from diverse representations and their own lived experiences.

8.11 Future Publications and Policy Implications

As social care prepares for statutory registration the language, terms of reference and definitions provided for social care work within the documentation supporting

regulation will have implications for the future of social care work. The key findings in this thesis relate to the practice in diverse settings, the development of the workers' identity and the influence of context on the workers' experience of social care and of self. With regard to practice, the findings suggest that policies relating to social care work need to redefine the role of the relationship, thus acknowledging how situated knowledges present practice as holistic and embodied, where the relationship is understood as the centre of it all. The workers' identity is affected by their practice where multiple identities are claimed and performed, and it is also important to acknowledge the influence of their early motivations to care on current practice. The findings also suggest that professional identity is given only limited attention within the workers' social care education which has implications for programme design and delivery. This is the first study to emphasise the importance of the contexts of care and how the setting influences practice and identity. This study outlined the importance of creating a sense of home within both day and residential services for workers and how they use practice spaces for purposeful practice, and both concepts are missing from the standards of proficiency for social care. These key findings have the scope to influence policies on how social care work is defined. Dissemination of the findings to those influential in this field will begin with the following proposed journal articles;

- 1) Re-defining the relationship within CORU's Standards of Proficiency.
- 2) A Foucauldian analysis of the social care worker and the impact of surveillance, regulation and the subjection of self on the workers' experience of practice within diverse settings.

3) The implications of the diverse representations of social care work in the current policy context in Ireland.

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Appendix 1: Ethical Approval Form



ucc

Coláiste na hOllscoile Corcaigh, Éire
University College Cork, Ireland

Denise Lyons,
Dept of Education

16th May 2013

Dear Denise,

Thank you for submitting your research (project entitled Head, Heart, Hands and Habitat – A knowledge Base for Generic Social Care Education #175) to SREC for ethical perusal. I am pleased to say that we see no ethical impediment to your research as proposed and we are happy to grant approval.

We wish you every success in your research.

Yours sincerely,

Sean Hammond
Chair of Social Research Ethics Committee

Oifig an Leas - Uachtarán Taighde
agus Nuálaíochta
Office of the Vice President
for Research and Innovation

Uirlár 4, Bloc E,
Áras na hEolaíochta Bia,
Coláiste na hOllscoile Corcaigh,
Bóthar an Choláiste,
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4th Floor, Block E,
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Professor Aislinn Maguire BSc PhD CCrim MRSC
Vice President for Research and Innovation

Ollscoil na hÉireann, Corcaigh
National University of Ireland, Cork

Appendix 2: Revised Ethical Approval Form



Denise Lyons,
Dept of Education

5th March 2014

**Oifig an Leas - Uachtaráin Taighde
agus Nuálaíochta**
Office of the Vice President
for Research and Innovation

4th Floor, Block E,
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University College Cork,
College Road, Cork, Ireland.

T +353 (0)21 4903500
E vpresearch@ucc.ie
www.ucc.ie

— Dear Denise,

Thank you for submitting your revised research (project entitled Head, Heart, Hands and Habitat –A knowledge Base for Generic Social Care Education #175) to SREC for ethical perusal. I am pleased to say that we see no ethical impediment to your research as proposed and we are happy to grant approval.

We wish you every success in your research.

Yours sincerely,

A handwritten signature in cursive script, appearing to read 'S Hammond'.

Sean Hammond
Chair of Social Research Ethics Committee

Professor Anita R Maguire BSc PhD CChem MSc
Vice President for Research and Innovation

Ollscoil na hÉireann, Corcaigh
National University of Ireland, Cork

Appendix 3: Information Pack and Letter of Consent



Dear Social Care Worker

I would like to invite you to participate in a major research study aimed at exploring the experiences of what it is like to be a social care worker in the different areas of practice.

I am looking for social care workers with an approved social care qualification and at least two years' experience in his/her current setting.

Please Read the following information about the research project and if you would like to participate please sign the consent form at the back and return it to

Denise Lyons
Institute of Technology Blanchardstown
Blanchardstown Road North, Dublin 15

Denise.lyons@itb.ie 0877780625

INVITATION TO PARTICIPATE IN THIS RESEARCH PROJECT

Introduction Information

Research Project Title:

Head, Heart, Hands and Habitat –Being a Social Care Worker

What is the Purpose of this Project?

Social care education has evolved dramatically in the past forty two years from the training of care workers for residential care (one service), to the current position where we educate students to practice in a variety of settings including disability, homeless services and elderly care to name a few. However what is not evident is how the practice of social care work has evolved and what is the experience for the social care worker now within these settings. Thus, this research will explore how social care is practiced in different settings and the experience of being a worker in this setting.

Who are the Research Participants?

The research aims to include the experiences of both male and female qualified social care workers within the following settings; disability, residential care for children, homeless, mental health and community care. The workers will have an approved social care qualification and at least two years' experience in practice.

What Will You Ask From Me?

One Interview and 3 Photos of your Practice Setting

I would like to interview you on what being a social care worker means to you; your thoughts about relating to others; what skills, knowledge and attitudes are needed, and what it is like to work in this particular setting. As social care practice occurs in very different spaces, I would like to include photographs of the areas that you mostly work in with your clients or service users.

The interview will take approximately **ONE HOUR** in a location of your choice. In some case a second visit may be required.

2-3 Photographs: 'The Spaces you Work in' (Without People)

Please take photographs of the different areas that you primarily 'work in'.

-Please ensure that you have permission to use the photos.

-Make sure that the space is not recognisable as belonging to your service. If confidentiality is compromised you may want to focus on a specific piece of furniture or the most relevant corner of a room.

Denise.lyons@itb.ie 0877780625

USING IMAGES IN THE RESEARCH –Within the Interview we will use images to help me understand your experience of practice in this setting

This is the proposed cover for the New Social Care Ireland book on Practice –

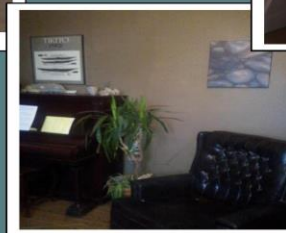
Q. What object(s) would you put on the window sill to describe your practice?

Social Care Learning from Practice



Edited by Noel Howard & Denise Lyons

TAKE 3 PHOTOGRAPHS OF THE SPACES YOU DO YOUR SOCIAL CARE WORK IN AND GIVE EXAMPLES OF PRACTICE



INTERVIEW QUESTIONS

Describe your journey on becoming a social care worker in this setting?

Describe this setting and the role it plays in the lives of your service users?

Social care practice is described as a job where being with others and meeting the needs of others is central to the work. Does this relate to your role as a social care worker here?

Describe a typical day?

What does being a social care worker mean to you, in this setting?

What are the key issues that come up for you in this work?

Many theorists define social care work as involving our head, our heart and our hands (thinking, being and doing) does this relate to your understanding of being a social care worker?

How does this setting differ from other experiences you have had?

Have you changed/evolved as a worker, how have you grown and what encouraged this?

What would you put on the window sill and why?

Using the photographs you provided, can you describe what is in the photo and give examples of some practice experiences you have had there?

ETHICAL ISSUES

Do I have to Participate?

No, your participation in the research project is voluntary, and you have the right not to accept this invitation to participate, to refuse to answer any questions in the interview, or ask within six months of the interview for aspects of, or all information provided to be withdrawn from the study.

You can leave the project at any time, without prejudice or consequence.

Will I be Identifiable in the Study?

Your anonymity will be maintained at all times and neither you nor your service will be directly identifiable within the study. It is my intention to publish the findings of this study and neither you, nor your service, will be directly identifiable in any publications.

A Leap Forward



Research –A Leap Forward in Understanding Current Social Care Practice

The PhD Candidate Denise Lyons is a social care worker and she worked with children in residential care and adolescents with ASD. Denise became a social care lecturer in 2000 and is particularly interested in the professional and personal development of students during their training.

Research Study

This research is being undertaken as part fulfilment for the PhD in Education at University College Cork, supervised by Dr. Maura Cunneen and Dr. Karl Kitching.

Informed Consent Form

Title of Study: **Head, Heart, Hands and Habitat- Being a Social Care Worker**

I have read the introduction letter and I understand that the main aim of the research is to compare the views of social care workers from different services on their experience of being a worker.

I understand that my participation in this project is voluntary, and that I can withdraw at any time, or refuse to answer any questions, or remove my information from the study within six months of the interview, without reason or consequence.

I accept that my identity will remain anonymous, and that I cannot be directly identified within this study or any subsequent publications. I also understand that my information will be stored for seven years after the completion of the study.

I give my consent that the images provided can be used as part of this study and any subsequent publications.

I hereby give my voluntary consent to participate in this study by signing this informed consent form. I understand that I will receive a copy of this form.

Signature of Participant ----- Date.....

Address and contact
number.....
.....
.....

Signature of Researcher-----Date.....

**A signed copy will be returned to you to the address stated above
Thank you for agreeing to participate in this study**

Appendix 4: Student Consent Letter

Student Informed Consent Form

Title of Study: **Head, Heart, Hands and Habitat- Being a Social Care Worker**

I understand that my participation in this project is voluntary and that I can withdraw from this session at any time, or refuse to answer any questions.

I accept that my identity will remain anonymous and that I cannot be identified within this study or any subsequent publications. I also understand that my information will be stored for seven years after the completion of the study.

I hereby give my voluntary consent to participate in this study by signing this informed consent form

Signature of Participant -----

Date.....

Appendix 5: Metaphors from the Case Clusters

Case Cluster 1 Researcher-led Photo Elicitation

Using a similar approach to the practice stories, the discourses from the research-led photo elicitation were analysed and structured under the emerging themes. The participant was shown a photograph and asked to relate this image to their practice setting ‘what would you put on the window sill?’.

Homeless Services		
<i>Participant / Symbol</i>	<i>Participants' Explanation of the Symbol</i>	<i>Co-created Discourse</i>
Jim - A candle	One of the people that lived us lost his place here due to very unsafe drug use, and he died very close by. The guys downstairs decided that they would honour him to by putting a lighted candle in the window, just honour that space, so as not to be religious and all that, and I thought it was very profound. They lit it every morning, and they left it there until they burnt it down to the bottom. Kind of light of hope or you know, something that's welcoming.	Emotional connection, service user led initiative, symbol for home and welcome. Dealing with grief and death.
Colm - Rope bridge - House key	A picture of a hand opening the front door with their key, it's the evidence that clients move on, it's about the way forward, pushing forward.	Journey towards the unknown, risk, fear of taking the next step, moving on, transitions from here to there. Moving forward.
Bernie - A plant - Books - A cup of tea	A plant or books or the cup of tea maybe. Maybe a plant or something as we try to create a normal space. We have a very similar window ledge and what is actually on our window ledge is books.	A sense of ‘Normal’, making feel like home. Importance of communication, sharing spaces. knowledge

<p>Clare</p> <p>- A Home</p>	<p>A house, a home I suppose rather than a house, a home. I see a family settled in a community with enough supports around them, family or friends, like what I had growing up that made my home a stable home. I think a family struggles and is in crisis when they are in emergency accommodation for lots of reasons when they are in their home they can actually take a breath.</p>	<p>Figured worlds, home is security and comfort, moving towards home.</p>
<p>Youth Crime Prevention</p>		
<p><i>Participant / Symbol</i></p>	<p><i>Participants' Explanation of the Symbol</i></p>	<p><i>Observation of Analysis</i></p>
<p>Joan</p> <p>- One word 'Respect'</p>	<p>I would try and put up a word, respect, because if I don't respect the clients, I am working with they are not going to respect me. I would just put two people sitting in front of each other because it shows that one is talking and somebody is listening. I think that's very much what it's about it's about, interaction really. Meeting somebody face to face, social care is only so much if you can't interact with people you are not going to last in this profession.</p>	<p>Respect and interaction, connecting face to face.</p> <p>It's about interaction.</p>

Case Cluster 3: Photo Elicitation from Disability Service

Disability Services		
<i>Participant / Symbol</i>	<i>Participants' Explanation of the Symbol</i>	<i>Shared Elaboration</i>
<p>Simon</p> <ul style="list-style-type: none"> - A Teddy Bear - A book - Map of the world 	<p>I suppose the teddy bear is caring; it can be a bit babyish. The teddy would represent at least of one ladies very well. She likes to be looked after; she likes to be cared for. A 40-year-old woman who likes to go to bed with a teddy bear at night.</p> <p>Would represent the bit of learning and the independence and the lads pushing themselves forward and becoming better, and the staff the supporting them to do that.</p> <p>To get out there in the community and to expand. The map of the world would represent their push forward, and what staff focus should be on. Our lads like to get out; they like to be doing things.</p>	<p>Represents one resident, their likes and personality.</p> <p>Vulnerability of service user</p> <p>Represents group activity of service to push and support.</p> <p>Aspirational aim - the focus 'should' be, to get people out into the community.</p>
<p>Paula</p> <ul style="list-style-type: none"> - Multi-sensory toys 	<p>I would have a colourful teddy, and I would also have musical sensory toys that make noise and light up. This is what they play with, and most kid's bedrooms have them.</p>	<p>Play, toys. Making the bedroom a personal space.</p>
<p>Liam</p> <ul style="list-style-type: none"> - A Personal photograph 	<p>Personalise it with a picture of somebody something that it is personal to the guy, something that keeps him motivated and keeps him focused. I have a picture up on my wall in my office of me and the young chap who is learning to cook.</p>	<p>Personal and meaningful to the service users and the staff.</p>
<p>Ava</p> <ul style="list-style-type: none"> - A Wii 	<p>One SU would spend a lot of time playing the Wii, and then the batteries go, or he can't work a game, it can cause a lot of difficulties. Somebody said a good few weeks ago we must get him one of those sand pits and a water station for the garden that he can mess around in the garden, it just hadn't been done, nobody had the time to go and do it, so I am hoping somebody will.</p>	<p>Day to day challenges with individual service users. No time to invest in service user projects requiring imagination.</p> <p>Staff time pressure, admin /</p>

- A big Clock	Time is a big issue, time to get anything done, you are under pressure. And time to file, the filing has become a huge issue.	managerialism. No time/resources to put good ideas into practice.
Una - A mobile phone or a laptop	Technology offers our community a wonderful new world and method of communication. Years ago the only way of contacting friends or family was through a "minicom" this was a specialised phone that they would type the message and the operator on the other end of the phone would either tell the person what was being typed or if the recipient of the call was deaf they would forward the message. As you can imagine, not at all private or practical. Now with laptops, they can now 'Skype' friends and family.	New role of AT in social care.
Kate - African figure	We kind of help people communicate where they are at and that way they are able to move forward as best they can then. African figure a mother and child, the mother is encircling the child, there is an openness as well, maybe the circle isn't closed, you know just to show that there is support but also that there is an opening for independence, an opening for forward thinking.	Communication and support, caring and promoting independence and forward thinking
Laura - A cup of tea	Our best chats, we get information, we get people to relax and calm down. During one to ones, you get the most out of people. They sit down, they tell us about their weekend. We have music while they are having their tea and you actually see the personality come out through that.	Rituals of daily living shared moments of connection and communication
Alice - A single white rose	A rose, it's beautiful and maybe a white one, because it represents purity, and a lot of people that we work with are very vulnerable, and a flower then is vulnerable itself. A rose because it has thorns in it. I think a lot of the people that we work with are very resilient to be able to put up with the different changes that have occurred. The more we see things from people's perspectives, the more we grow.	Betwixt and between vulnerable and resilient. Growth of service users and workers.

<p>Rita</p> <ul style="list-style-type: none"> - Big arms around whole person 	<p>It's holistic; it's the whole person you have to mind, it's their emotional needs, their physical needs, their social needs. It's not just the minding; sometimes you have to push people. It's the whole; keeping in touch with their families; creating a homely atmosphere, not all the admin stuff and all the documentation and all that. Safety is not just making sure you have an emergency evacuation plan.</p>	<p>Human touch, warmth, homely feel, caring. Pushing service user's forward, and staff pushing back against managerialism.</p>
Mental Health Services		
<i>Participant / Symbol</i>	<i>Participants' Explanation of the Symbol</i>	<i>Analysis</i>
<p>Michelle</p> <ul style="list-style-type: none"> - Big Caring hands 	<p>It's just very much a symbol of support, care and I'm thinking of the warmth of hands. Extending out your hand or cupping them together just to nurture someone.</p>	<p>Warmth, humanity, touch, nurture</p>
<p>Samantha</p> <ul style="list-style-type: none"> - Open windows 	<p>A safe space, kind of letting what you let out in here out the window. Young people coming in here can let out what they need to.</p>	<p>Safe space to share and let go</p>

Appendix 6: Practice Stories

Case Cluster One: Homeless Services/ Addiction

“In outreach we used to work with under 18s in outreach as well and we had an under 18 who turned 18 so he went from being priority to us meeting him every weekend, getting him breakfast, basically babysitting him to him being 18 and us not having the provision to provide that service to him anymore because we only have under 18s, and he was my client so I was working with him as an adult and he was upset that he was not as important essentially as he was before so we had some time and I brought him into our building which is normally closed at night-time and brought him in and sat him down and made him a cup of tea and made him a sandwich and talked to him about his current situation, you know his new situation as an adult versus as a child and we talked about how shit it was and just how it really is awful and it sucks and it's not right but we need to look at your reality right now and what do you need right now, I need somewhere to sleep right now, ok, so we need to get you into a hostel, I am not staying there that place is a shithole, ok so let's see what we can do, anyway, make and do your advocacy, we advocated then to what was then the Freephone for a new vulnerable young person to get one of the nicer hostels and at the time this hostel was single occupancy so anyway that's where we got him in and the crisis was averted for that night but the social care work was the making the cup of tea, it was bringing him indoors, it was him having a sandwich and it was having that conversation and it was empathising that yes, your situation sucks, I am not going to pretend that it doesn't, I am not going to sugar coat it for you or say that it will be ok, right now, what's happening for you right now this minute is crappy but what is the main need for you right now and can we resolve that need right now and work on the other things tomorrow” (Bernie).

Well I would say young, in her 40s, that over the months slowly working on it, now this was a person who would have self-harmed as well in the service and would have kind of severely self-harmed in the service, you know that kind of way, so it's about us dealing with that but that's how she dealt with the kind of how she was feeling, that kind of way, but at the end of it, not so much at the start, at the end of it she had got her own place but the growth and the development and the smile, that wasn't there at the start, was there like she finally smiled and finally, as she was going out the door with tears, she came in the door with tears of sadness but going out the door with tears of joy but like for me it wasn't, the self-harm wasn't there it was prominent in the weeks before she moved out, do you know that kind of way and this is stuff you have to deal with, you know that kind of way in your approach and things like that where

there is clients at times when you walked in they would be self-harming, and you wouldn't jump and grab them, you would just sit down and say what's going on what's happening and they could be doing it still in front of you, but it's how you approach and how you deal with it, the worst thing you can do is start grabbing stuff and taking stuff out of their hand, you don't do that, and you can't also start hiding stuff but anyway. With her moving out it was like for me coming back, even when I have left the job or left that day and that week I was thinking about her, I even touched base with myself at times when I think about things like that and decisions that we made around that certain case. There were times where we looking a higher support due to her behaviour and how she was and within herself but looking after her own safety, does she really, is this suiting her is this looking after her own safety, are we going by best practice but also for me it's about, like, looking at that but thinking of those situations and the reason why I do it it's like you are just looking at it, you are so humbled when you look at people that move on, that's the growth, that's the winnings that you get out of it. Like some people say that they get stagnated in jobs, and it's like the same thing but when you see people that come in and then a few months later when they move out, like that's, for us for me in any way you see that and you say the joy and happiness of just getting a key to a door like, it's all about self-reflection, self-reflection on my own practice, for me, on how I approach things and how I do things and how my practice affects the clients and how my practice affects the staff, in a positive or negative way and that's getting the feedback but that is something to bring back to people who are coming through social care it's about self-reflection, touching base with yourself and seeing what your approach is and how your approach is, how it affects clients and how it affects staff, but if you have that piece within you, the self-reflective you will go a long way, now you will self-reflect and say yeah grand, but it's about really self-reflecting on your practice and how you do things but also self-reflecting on the decisions that you made in relation to that person's life. You know finally she moved out, now really had to dig deep within yourself, there were times where she was moved to another accommodation because it was looking more like a high support but thankfully we made the decision as a team to kind of hold on and kind of, and that's a challenge as well when you come back to the challenge and say what are the challenges, that is a challenge as well, the challenging behaviour and things like that, but it's dealing with things like that but definitely with the clients moving on it's the, it makes me humble, but it also gives you that kind of you know" (Colm).

"I suppose say looking at a young person recently, and there was a real issue around, say, cannabis use, now I am not a drug counsellor, but I had this person linked in with a specific youth drug service. I thought this is going nowhere, I was like you are not really going to the appointments so they have to see that you are willing to engage so that they can pull in a referral to more, you have to understand what they are dealing

with in terms of drug use, basically yourself and so on, there is other stresses in his life around the money for spending, it was just really, it is their responsibility these people are all very keen, it's putting it back and listening, and active listening, and so yeah ok you are stressed because you spend so much money, what are you spending money on, Drugs, ok well let's do a little drawing here, so you are actually involved with the drawing piece, otherwise just another day would be gone, what the hell are you doing. But like ok you are spending money on drugs, it's causing you stress, then you get stressed and you want buy more drugs, then you are in more debt again, so it was a really engaging piece, it was nearly like a motivation interviewing piece that you hear about but, also then what's your plan. I sort of accompany him to appointments, every second appointment I go ok, I am stuck for time I will go to this one with you or so on, so it's sort of bridging that gap, so I am nearly handing him to someone but he is still my case but I am allowing him the opportunity to trust someone else as well, and I suppose the relationship with that particular young person stems back to when I was in residential care, and he just happened to come across the books again for aftercare, and it was just like perfect, I know this person, and he was 17 when I worked with him and now he is 19 and so that relationship was there so I was able to do that piece of real thoughtful social care where you are listening and you know putting a plan in place afterwards" (Frank).

"At the very start [of this job] of this when the workload wasn't quite what it is now I held a few cases, so I had half a caseload, I had about 7 children on a caseload, so I was working alongside the case managers, and I was doing a child support piece. There was a family came over from the UK, the Mum was originally from Dublin, she was homeless, so they were living in a B&B which was a disaster, and she had no friends, they were fleeing domestic violence, the Dad was trying to track her down, so she had to come off her Facebook page, there was lots going on for her and she was teenager as well and she was dealing with all the hormones that goes with that as well, so I worked with her and did a lot of one to one with her, and eventually I suppose had a bit of breakthrough when she made some disclosures to me. She realised that what I was trying to do was support to her to make the transition from Ireland to England as easy as possible, we also had to deal with very serious disclosure as well which was made, it was a retrospective one and the perpetrator was still a risk to children and that was massive as well because she felt that she was ratting somebody out that was close to her family, so it was kind of all that went on, but for me at the end of it was like Yeah, I can still relate to teenagers and it still works, the approach that we use as social care workers or that I use as a social care worker still works, and she learnt to trust me" (Clare).

"I had a really difficult situation, and I suppose this was when I was in [treatment centre] so it would probably have been my second year working in the field and I was

in a women's residential centre and I was working a lady who, you know, she was displaying some pretty challenging behaviour, she was quite angry, she was very angry and I suppose I sat with herself and the manager of the facility. I think what had happened is this particular lady had gotten into a bit of conflict with another lady who was living in the facility, so we brought them, myself and the manager brought both into the room, we sat down and we trying to just get them to resolve this conflict, but anyway I said something, I can't even remember what I said to this lady but she just reacted, she stood up and she got quiet, I felt very intimidated by her and I got up and walked out of the room and I gave myself such a hard time for probably an hour after I had walked out of the room because I had felt, my initial reaction was, oh God you didn't look professional in this situation and you know you shouldn't have walked out and kind of left the room you should have been able to deal with that a little bit better, but when I was able to sit back and think about that and kind of draw on, I suppose my skills as a social care worker, and I suppose the work that I had put in and what I had learnt, particularly through the professional development modules, I was able to sit back and actually say, you know what this is ok, nothing wrong has happened here, and you just learn from that experience. So I think I kind of really learnt not to beat myself and up and that making mistakes or maybe doing things the way you know that you didn't necessarily want to do them is actually a really really good thing because that is how you learn and unless you make those mistakes, you know, you will continue to make them or unless you actually spend a bit of time to really reflect on them and think about what has happened and be able to move on from it and to may tweak your practice a little bit then, you know that it's ok, it's ok to be human and I think that if I was to just kind of walk into a position maybe, without having the training that I have had I don't think that I would have the confidence or I don't think I would have the security in myself to be able to deal with situations like that and kind of pick myself up and move on from them " (Sheila).

"There are some clients here who's motivation may not be recovery, some of the motivation is, we always have a percentage of the clients who are quite negative and so the motivation could just be to get out of prison, which is fine, I wouldn't want to be in prison either, I would rather come down here would can see your family and get out on social trips and things like that, and you know sometimes when the lads, when some of the lads come down from prison their motivation genuinely changes and they do genuinely want recovery even though initially it could be to get out of prison, or court or something like that, it does genuinely change then, but then we always a percentage of clients that aren't really here for the right reasons so we have to essentially manage that because that can have a really negative impact on the community. They could behave in ways that isn't great. We do have times where, not all the time, every now and then, where there could be drugs on the facility and things like that and you are discharged if that happens. So it's really kind of trying to contain

that and manage it. The likes of now if you are in day programme, let's just say you go in the morning and you start your day off following up on the interventions from the night before, do you know what I mean, so that can be quite challenging, you know, kind of staying on top of everything can be difficult. And we have to be very mindful that there is a parallel process as well, what I have found over the years is that if the staff team are a little bit all over the place and bit scattered, not intentionally, just because it's such a fast paced environment it tends to be a reflection on the community. You know you see the community and the staff team are kind of the same" (Joanie).

Case Cluster Two Disability / Mental Health

"Near the end of my time there, one young man died in our care. Well he had actually just moved out of care, but we were still supporting him, nobody in the world was knocking into that boy making sure he had food in his house, or money in his pocket, or was alive, but us. When he was in a coma in hospital the manager rang to ask if the homeless services were involved with him now, like we are not taking the hit for this, somebody else must take the hit, he was looking for somebody to blame. I rang him later and said you disgust me; you didn't ask how he was, how he was doing, what his progress was, how everybody was coping because everybody was mad about this young fella. It was an overdose, his dole didn't come through for six weeks when he first moved out, and we were subbing him, and then it all came in in one go. The staff got as much off him as they could for safekeeping, but he went off with like €200 in his pocket, off drinking and drugs and whatever he could buy for that amount of money. His mother was a heroin addict who kind of abandoned him because her new partner didn't want him, he was too wild or whatever, he lived on the streets a bit, and then he lived in hostels, he also did some time for drugs. Even while he was with us his Mum had no time to spend with him; she even got him to test her heroin for her. This lovely young man who wouldn't even be comfortable to sit in McDonalds and eat a McDonalds was so paranoid about what people thought of him and the only people he felt comfortable with him were the staff or homeless people. People who just didn't fit into society, he didn't feel he had a place at all. The organisation wouldn't even contribute to his funeral, really despicable. So I think I had enough of that hard side of life because it's really hard, and not that the disability services is not stressful, but they have families who care about them largely. They may not be able to cope with them, but they look after them, they take them home for the weekend, and they care about them I and I think for me that's easier, that's why I wanted to work back in this sector. I think that makes it easier, you are not always on the hard face looking at the harsh realities that some people have to deal with, so I suppose it nice to get away from that.

“Well for example the back of the apartment there is a garden and one of the girls she enjoys, we got her a paddling pool and she loves playing with it, she is non-verbal but she is very vocal, but it was 1 o’clock in the afternoon she is no louder than a couple of kids would be but the lady who lived behind the wall put her head over, and she was furious, she started taking pictures and everything saying she was going to go to the guards and she said bring her in I am having friends over, and I don’t want them to hear her, and I just thought oh it’s really sad like. Imagine if that was your daughter or something and I thought hope you never have a family member with a disability. You do not very often, generally people are quite good but, and another thing as well, and they mean well but sometimes when you are out with the girls you can encounter, a couple of times it’s happened to me where people come up to you and go fair play to you, you are so good and everything they are trying to be nice but really from the point of view of the person that you are with what must it be like for them you know going is it that much of a task to be out with me. So yeah I suppose accepting differences, and I think as well with adults, it relates specifically to adults because they are never going to change, that’s what they are, it’s not, so just accept them, rather than trying to change them” (Olivia).

“Yeah em the house that I was in that I was running was always kind of known as the party house, everyone always came to us we always had birthday parties, barbeques, we’d get like you know the takeaway barbeque things. But like, I remember it was one day before I finished up in the house and remember that summer was so warm I was like –Do you know something lads we’re going to have an owl barbeque day, we’ll get all those programs done in the morning and we’re just going to do nothing for the afternoon, stick the barbeque on, go and get some burgers and sausages and things like that and it was great. The kids had no behaviours they were so happy, we had a paddling pool, two of the other guys, staff in the house had actually done a Teleback challenge and had raised money, and they bought an umbrella and a picnic bench for the house with the money. It was just a great day, then we got water guns from the local shop, and then we had the kids running around with us, and all the staff were soaked, and I know it’s terrible like I’m supposed to be like a good influence, but here we were running around wetting each other, barbeque going as well. It was just a brilliant day and to think days like that you’re going actually this is what it’s about, it’s a home, this is what would happen in a normal home, there’d be there would be water fights there’d be a barbeque everyone was happy, the kids were happy, there was no behaviours and everything just fell into place. Now there was three of us on with four kids the house was like an absolute tip like but we got then we were like right, seven o’clock came we were there right you do the baths, I’ll do the cleaning, you start on the reports, and it was just all right, it was a great team effort and things like that you are going yeah that’s a good day’s work, and then you can all look back on it. And there were also other days where we just put the kids into the people carrier

and go off for a picnic and get our coffees; you know they'd all be happy and come back and chill. You know it's days like that are good and rewarding like" (Paula).

We had a very difficult situation quite a number of years ago, without breaking confidentiality, we had somebody living at home, their home setting wasn't particularly safe and I was trying to gain the information in a very roundabout way from the family and then making, as an advocate, speaking to the social work team in order to get this person into a more suitable setting, so we were looking at this particular lady, as it was, and looking at her needs and where we could possibly fit her in into suitable residential setting and to do it in such a way that neither the family nor the service user nor the new setting was going to be affected negatively, so we worked for a number of weeks and we had lots of meetings with the family and the person and the new setting and eventually we were able to do the transition from home into her new residential setting and I think when I sat down afterwards I said, yes that was the best for the person and I think we handled it in such a way that nobody has had a negative effect from that experience and you know you were using your skills with negotiating with the family, looking at a needs based assessment for that person and then reviewing it afterwards and continuously over a six-month period to ensure that the right setting was in place for that person. I actually sat back afterwards and said, God, that's actually what I trained to do when I was able to use all my skills and all my training to actually have a positive outcome at the end.

What do you think you use specifically to enable that process to happen?

I think I used patience and negotiation skills in the sense that I was able to meet with the family without being critical of the old living situation. I was able to make them see that, you know, this wasn't meeting her needs, it wasn't meeting their needs and just being able to plan as well for the woman's new setting that we had everything in place for her needs, that I could sit down and say well what to do you want and I was able to use our individual planning system and sit down, and she was able to have, her whole new environment was just literally geared for her and then when we looked back the anxiety and the challenging behaviour that were present at home were beginning to dwindle so the fact that we were able to look at the behavioural analysis and do a positive behavioural support plan and everything was put into place and although I was getting other clinicians input I was using my skills and my knowledge and experience of previous moves of people and how they hadn't gone so well in the past, to put into place an easier transition for this woman" (Laura).

"When I came back, I was gone for a year and a half, and I came back, and there was a service user on medication that I was absolutely shocked that she was on medication

and in my heart, I said that's wrong, she's not right, she is sedated nearly. So I went and I did something about it, and she is off it, and she is a different person since. The group didn't notice how subdued she was and how flat, she was flatlining if that is the only way I can say it and I saw it, and now they see she is so much better and happier. So I think you have to be very careful that people don't follow a strong leader if they think they are wrong. Another example one lady who loves music and she sings a certain song, and nobody really knew what it was, but I did I knew the tune because I am the age of her, so I got it on my phone on YouTube and played and it's a way of getting this lady to just switch out of a bad humour so quickly. So we have got her an android tablet so we are in the process of downloading all her songs onto it with videos so she can look at but the difference in her, you can just look at her when her song comes on, and she just launches into it, and she loves it, so that's what it's about, thinking outside the box a little. I see her there, and I hear her laughing and then singing the song I say yeah right that worked" (Rita).

"I would have worked with a chap with autism. He comes from quite a troubled childhood being exposed to all sorts of films, and his mam had went through a nervous breakdown, and his sisters would have taken on the mammy role, the father tried to commit suicide in a bath, and he was exposed to all of that and found his father, but he never, I suppose with autism he found it hard to express his emotions and he had never, he had never cried before in his life and up until, at age 16 he was being quite challenging, we were putting in boundaries and rules, and we're all unified in our approach as a team. Now he is living at home with his family, it's going well for him but at age 16 he came down, and he whipped me with the cord of a lead his DVD or something like that, and I overemphasised, purposely overemphasised that emotion as you know I went ah that was really, really sore. I was just validating how I felt and how he put me through that, and he got the link between all of those if when he hit somebody it hurts them, I don't know if this is coming out right now, but it I suppose it was only in that moment where it clicked that his actions hurt other people emotionally and physically, and he broke down and cried, now I went over to the sitting room, and I put my head down and I was holding my shoulder and he was looking at me and he came over and he said I am sorry and he threw his arms around me, and he cried for Ireland, and even the social care worker that was beside him started crying because she couldn't believe what he was only after doing and when I touched base with his mother that night just to give her handover what had happened that day, I said that was the first time he ever cried and then she started crying. I suppose that was one moment that I thought was pretty special and then from there on in he controlled his emotions alright and he learned how to cry when it was appropriate rather than going out and lashing out at somebody or boxing or putting an armchair through the window, we would give him that time so he could have a little cry and

since that he has got a job, went through education system and now he is back living at home” (Liam).

“I can give a very good example from one that I have worked with, in a community setting. I did intensive work with a young boy who was in the care of his stepsister as his mother died and he was presenting with a lot of; I suppose attachment related difficulties mainly engaging in aggressive and disruptive behaviour. He was not managing in school, and he had poor social skills. His stepsister was a young adult as well, and she was sent from her home country to come care for him. He was not managing the school setting at all; he was acting out and was very difficult. He was undergoing an assessment for ADHD, but it was very much a case of supporting his sister in managing him, building on their relationship. She attended parenting sessions with me on an individual basis. I did Marte Meo work with them focusing on their relationship. I linked her up into community support groups with other parents, and we got him linked into after-school projects. In school, we applied for a SNA and resource hours. My focus was to ensure that he didn’t go into care; I had the support of a primary care social worker. I remember when I was discharging him I listed all of the different interventions in his discharge letter and I said to myself that I did a good piece of work with that family. In the end, he was discharged, and there was never a need to re-refer him.

Denise: And within that situation what do you think, I suppose, aided you to do that work.

Michelle: “I was using all my specific therapy training and experience. I did a lot of networking with agencies in the community and understanding what was available in the community, you know from all the early assessment work we did and everything, there was a lot of different interventions, working with family, a lot of collaborative work with different agencies, working with the extended family network of the young boy and his stepsister, you know friends of the young boy’s mum who was involved in the his life and getting them involved and getting all the supports in place for him because he needed that. He attended for two years. But it was basically building and reconnecting his relationship with his sister that was the real success because she was not in his life and she barely knew him” (Michelle).

“Oh it can break your heart at times, and then other times you would see some beautiful achievements. Like we used to have a child that used to go in and trash her room everyday just because the sky wasn’t blue enough for her, for no apparent reason, we

could never find a trigger, but then we learnt this is just her routine, she likes doing this but we discovered she likes the tidying up afterwards of her room, so we just ignored it, planned ignored it for a long time, now we did put in a room of her own only because we thought that that's what she wanted, her own stuff to trash because she would never touch anyone else's, it was just her own, so we gave her a room of her choice, would you like a room, yes please, and from that day on she has never trashed her room, and that girl left us this year. For the simple reason, we always claimed we have to fix things in social care we find out what's root of the problem, what's the trigger, what's the, sometimes there are no answers. These things could work out themselves, and it's a phase they are going through, about our own, like you have your own children, and they are going through this phase, you know, you don't analyse it with your own children but yet you analyse it when you are in the workplace, and it's not always the answer" (Una).

"The referral that had come in was that she was very anxious because she had passed wind in class and wouldn't be able to go back into the classroom and I suppose that something that I, even when the referral was read out, and it was a word the words that GP used I found so funny and you know one of the girls, actually she is a social care colleague said you would be the worst person to work with that girl and I said no I probably would be the best person I said that because it is something that people find funny so anyway the consultant agreed and she came to me for work so we would have very much, I would have said from the outset listen this is something that I find funny and when we are at the end of working together it will be something that you will probably find quite funny as well, that you don't take it so seriously anymore, because she didn't have IBF but she did have something when she was very anxious it caused a lot of wind which can happen with anxiety, so we would have done some anxiety management and then it came to the kind of behaviour experiments where we were kind of putting our heads together and getting her out and about and allowing herself to pass wind to see if these terrible things had happened, would happen and the end goal was that she wanted to be able to go her debs, that is what she really wanted, but was so terrified that she couldn't even bring herself to even think about going to her debs, so I would have done work with her, would have met her downtown, would have gone into shops, you know kind have talked through predictions before, how she could manage her anxiety during and it went afterwards, so a lot of work in relation to that but we got to the end goal, where she went to her debs and I actually went too, you know the way it's a whole big gathering so I would have actually gone to it and now, again I wouldn't have gone up to her but just to go and kind of see her and let her see me because I promised her I would, but she came over, she had looked beautiful and she came over and she was just so delighted that she had made it and it's my debs and I will fart if I want to kind of thing, so and that's what she said and I said well I said you know that nothing terrible will happen if you do, so that was really the end of the

work but that was kind of pulling on all resources, and allow me to be me, because sometimes you just have to laugh, sometimes it doesn't have to be so serious and she, she got that and it went really well, so that was kind of the end of our work but I suppose it's just again kind of going the extra mile outside of theory to ensure that she got to where she needed to go" (Samantha).

Case Cluster Three: Children's Residential Care

"We have one young person that some of the staff team find very challenging. She [Young person] is away for 10 days now and on a trip, and I picked up the phone and I just rang her up and said "Hey honey I haven't seen you in ages how's things buddy, I just want to link in with you and see if you are alright" and no one else has thought of doing that, do you know what I mean. She will remember that, so when she comes back, she will say she will go Adam rang me up, that's my way of making sure my shift will run smoothly, and then if she gets a bit aggro I can bring her back down. Little things like that" (Adam).

Appendix 7: Nine Principles of Social Pedagogy

Principles of the Pedagogic Approach:

“A focus on the child as a whole person, and support for the child’s overall development;”

“The practitioner seeing herself/himself as a person, in relationship with the child or young person;”

“Children and staff are seen as inhabiting the same life space, not as existing in separate hierarchical domains;”

“As professionals, pedagogues are encouraged constantly to reflect on their practice and to apply both theoretical understandings and self-knowledge to the sometimes challenging demands with which they are confronted;”

“Pedagogues are also practical, so their training prepares them to share in many aspects of children’s daily lives and activities;”

“Children’s associative life is seen as an important resource: workers should foster and make use of the group;”

“Pedagogy builds on an understanding of children’s rights that is not limited to procedural matters or legislated requirements;”

“There is an emphasis on teamwork and on valuing the contribution of others in ‘bringing up’ children: other professionals, members of the local community and, especially, parents”;

“The centrality of relationship and, allied to this, the importance of listening and communicating.”

(Petrie et al., 2006, p. 22)

Appendix 8: Pilot Study with Social Care Students

Although, I was not using students as units of analysis, or a survey method in the final study, Yin (2009, p. 92) argues that “pilot cases may be conducted for several reasons unrelated to the criteria for selecting the final cases in the case study design”.

Pilot Study Social Care Students: As discussed, social care is a broad field which has evolved into diverse care sectors, and limited empirical evidence is available on the practice of social care *within* different areas of practice. I decided to do a pilot study with social care students after they returned from their practice placement⁷⁵. The pilot study was used to test the significance of Pestalozzi’s trinity of ‘head, heart and hands’ (Brühlmeier, 2010) to the student’s practice experience, and to get an initial picture of the availability of qualified social care workers in the placement setting. The pilot study was conducted on the 9th of January 2013 in the Institute of Technology Blanchardstown with the permission of the Head of School for Business and Humanities. The pilot study included seventy-four students (40 third year and 34 second year undergraduates). Before initiating the research, all second and third-year students were informed verbally about the study. The students were then invited to sign a consent form, agreeing to participate in the study voluntarily (see Appendix 4). The students were informed that this study was not being assessed and that their anonymity was protected⁷⁶, and each respondent was informed that they could withdraw at any time. Alternative workshops were provided during the time slot for any student not interested in participating in the study. The participants (n=74)

⁷⁵ Practice Placement in the Institute of Technology Blanchardstown is thirteen weeks, 35 hours per week in one approved social care setting.

⁷⁶ The submissions were anonymous; no names were collected beyond a general description of the service.

were divided into focus groups based on their placement setting and/or the similarities between their placement experience. There were thirteen focus groups in total⁷⁷, with participation varying from three to nine members in each group.

During the discussion stage and after the research was completed, some students shared the experience of not having a qualified social care supervisor, and in some cases that the placement did not appear relevant to social care. In these placement settings, the student did not have direct contact with service users or indicated that the placement setting itself did not deal directly with people. Students described ‘good’ social care placements as those with qualified social care workers as supervisors and where they had direct access to service users. The responses indicated how the individual setting influenced the knowledge required and the varying skill set relevant to the specific service user group. However, the most similar responses were provided for the values (heart) needed for social care practice in their specific placement setting; caring, having a non-judgemental attitude, being patient, empathetic and having a sense of humour. Data collected from the pilot study also provided a guideline for the case purposive sampling of settings where social care work is most evident. This was based on the student responses about the ideology of the service, if the centre employed a social care worker and if it adhered to a social model of care.

⁷⁷ Two focus groups for each setting; 1+2) Youth Services, 3+4) Day Services for People with Intellectual Disability, 5+6) Children’s Residential Care. One focus group from each of the following settings; 7) Travellers Service, 8) Residential Care for People with Intellectual Disability, 9) School Completion Programme, 10) Residential Care for People with a Physical Disability, 11) Women’s Refuge, 12) Acquired Brain Injury Service, and 13) Addiction /Homeless Service.