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EDITORIAL

By Anna Deneher, Guest Editor

In the autumn edition of the Irish Social Worker, the previous editor, Monica Egan, signed off her last editorial by noting that she had edited the journal since 2006 and that the time had come to hand over to others. She reflected that since social work has become a registered profession, that registered social workers should now take up the baton, and that the Irish Social Worker going forward should reflect that changing world. I am happy to take up the baton on this occasion and would like to take this opportunity on behalf of all members of the IASW to thank Monica for the past seven years of editing the Irish Social Worker, for her contribution to the Association over the years as an active member and as a past President, and to wish her all the best in her new sphere of work.

Since the last edition was published there have been further changes in the Association. At the recent AGM, several new members of the Board of Directors were elected, as well as a new Chair, Dónal O’Malley. I wish Dónal all the best in his new position and in building on the work carried out by Ineke Durville, outgoing Chair and previously President of the Association since 2008. Ineke is to be credited for her many years hard work in raising the profile of the Association, in increasing the membership and in establishing the IASW as a registered company. With the departure of Monica and Ineke, it is certainly the end of an era for the Association, but also a new beginning and a challenge as the profession moves into new and exciting times.

Change at all levels, new beginnings and challenges are integral to social work on a daily basis. And so it has been for those of us who work in the area of children and families, that 2014 heralded the beginning of a new era with the establishment of TUSLA, the new Child and Family Agency, followed by the publication of the Children First Bill, and more recently the appointment of a new Minister for Children.

In the first article of this edition Caroline McGregor examines the initial views and experiences of social workers and social care workers to the new Agency, ‘the biggest systemic change in the child welfare system since the establishment of community care post the Health Act 1970’. In the survey, most respondents believed that the Agency would have an impact on improving quality, consistency, enhancing accountability, and more efficient interagency and interdisciplinary working. Hope emerged as an important theme, and while many challenges and concerns were expressed in the responses, many responses also alluded to hope for change nonetheless.

The theme of hope for change is echoed in the next article. Joseph Mooney’s research focuses specifically on one area of the child and family social worker’s role under Section 3 of the Child Care Act 1991; the responsibility to accept and assess retrospective reports of child sexual abuse. The findings of this research will confirm the views of many social workers involved in this area; variations in practice, lack of guidance and standard procedures, and ‘system-level failure to meet the needs of adult survivors, current children and alleged abusers alike’. All social worker participants in this research called for greater clarity in the area and further guidance from management, and this is but one of a number of challenges for the new Agency.

Following on from their article in the autumn edition, Seamus Ryan and Michael Byrne’s article explores the needs and expectations of social workers regarding psychology provision in child and family services and ascertaining what additional services psychology services could provide to meet these needs. The low response rate of 10.5% to this survey has already been commented upon by Monica Egan in the previous edition, but it is worth reminding social workers of the importance of research in highlighting issues and informing the profession in relation to its practices. The finding that the vast majority of social workers would like to see a psychologist attached to their team on a full-time basis is timely given the current lack of clarity regarding the role of psychology in the new Agency.

Communication with children is an integral part of the work of social workers in the Child and Family Agency, and one such social worker, Lisa O’Reilly, found the verbal interview process to be a difficult experience for children and did not feel she was gaining an adequate insight into their world to ensure their safety and protection. Following her studies for a diploma in play therapy, Lisa found that children were able to communicate their world in a child-friendly manner, and so she continued her studies for a PhD. The article published here is a summary of her thesis, the research for which was designed to investigate the role of play in supporting communication between children and social workers during child protection and welfare assessments. The conclusion of the study is that social workers need to use play skills to build relationships with children in order to gain insight into their world and to communicate with them about painful and sensitive issues to ensure their best interests are met.

The final two articles in this edition look at the role of the social worker in primary care, a comparatively new role for social workers in Ireland. Muireann Ní Raghallaigh, Suzanne Quin and Rosemary Cunniffe’s article is based on an exploratory study conducted with primary care social workers in 2011-2012, aiming to gather some basic information about the role of the primary care social worker in the Irish context. The study findings offer insight into a new and evolving social work role. Many respondents related to the attractiveness of working with a wide range of clients, who were voluntarily seeking a social work service, the opportunity for preventative practice and to use a range of methodologies in their work. The primary care social workers also involved themselves in a range of community work and community development activities and ‘demonstrated a true generic approach of a community-based system, much as had
been envisaged for the original community care social workers in the early 1980s’. All of which, I am sure will reverberate with many social workers as reasons why they entered the profession in the first place, whatever area they work in presently.

The final article by Alison Duggan picks up on this theme of the community development and capacity building aspect of the social work role in primary care. The article describes a small-scale social justice research project carried out with the advice and expertise of the North Dublin Primary Heath Care Social Work team. The project aimed to identify the most vulnerable groups of clients and encourage social work advocacy for better resourced services and fair payments. The article reminds us of the importance of promoting social justice in practice as a role for social workers as outlined in CORU’s Code of Professional Conduct and Ethics for Social Workers.
THE CHILD AND FAMILY AGENCY 2014: INITIAL VIEWS AND EXPERIENCES OF SOCIAL WORK AND SOCIAL CARE PRACTITIONERS

By Caroline McGregor, Professor NUI Galway

INTRODUCTION:
The Child and Family Agency officially began business on 2 January 2014. Launching the Task Force on the Child and Family Support Agency in July 2012, Minister Frances Fitzgerald, announced that

‘This report proposes one of the most significant shifts in child welfare in the state’s history. It maps out a single way forward for Irish child and family services and a vision for a range of services, brought together in a manner that has never before been achieved. We are going to move from a position where child and family welfare was barely a priority, to a position where it will be the sole focus of a single dedicated State agency, overseen by a single dedicated government Department’ (Fitzgerald, 2012)

As it happens, I arrived back in the Republic of Ireland to take up my post at NUI Galway after 14 years out of the system albeit just over the border in Northern Ireland around this time (Aug 2012). It has been interesting, challenging and exciting to observe anew (as an insider in any case) the many debates and developments relating to the most recent attempt to reform the child protection and welfare system in Ireland. The changes since my study of child protection and welfare social work in Ireland during the late 1990’s and early 2000’s are palpable as are some of the ongoing continuities that persist amongst this change (Skehill, 2004). There are many dimensions to the new developments and the connections with existing practice to be considered and discussed and the possibilities for ongoing practice, policy and research development is significant. One dimension I was interested to explore in the first instance related to how practitioners at the front line were experiencing the transition and what they thought the impact of the Agency would be. Having listened over the past year to many discussions that have expressed views as divergent as ‘business as usual’ to ‘massive transformation’ and much in-between, I thought it would be interesting to give an opportunity to capture the voice of practitioners in a more collective manner. From work with my supervision of the work of Gabriela Dima on transitions relating to young people leaving care where Bridge’s model of Transition was utilised, I am also interested in the process of transition that is being experienced by what is arguably the biggest systemic change in the child welfare system since the establishment of community care post the Health Act 1970.

The study and results reported below are the outcome of a survey of social work and social care practitioners and represents Phase one of an ongoing study. The initial results were presented at the Child Protection and Welfare conference in UCC in October 2013 (http://swconf.ucc.ie/). The survey results collated at this point is the focus of this article. The survey remained open between Oct 2012 - Dec 2012 to increase potential for comparison analysis. However, only a further 8 responses were received during this time. The intention is to do a follow up study after the Agency has been in place for six months (June 2014). It is hoped that an increased response rate may allow for comparison of views at different points in the transition as well as more analysis of differences in views between (for example) social work and social care workers; managers and front line staff and/or new entrants and more experienced practitioners. As the study develops, the results will be published further. For now, I wish to share the initial findings from the first phase collated a few months before Tusla officially came into operation in Jan 2014.

METHODOLOGY

This initial study was based on a survey which was sent to all members of the Irish Association of Social Workers and Irish Association of Social Care workers. Social Workers and Social Care workers were selected for the study as they represented two of the main groups to be involved in front line child protection, child welfare and family support services. The overall objectives of the study were as follows:

• To give voice to practitioners ‘on the ground’ regarding a major period of transition
• To consider whether perceived impact of Child and Family Bill and Agency (Impact Statement, July 2013) is reflected by Practitioners
• To consider how perceived impact changes over specified period of transition to C&F Agency.
• To consider how impact is perceived depending on role and position regarding the C&F Agency.
• To identify priorities for the way forward

This phase has focused on the first two objectives cited above.

‘Survey Monkey’ was used and all members were sent a web-link to complete the survey via the organisation’s administration. By October 21st 2013, the cut off date for Phase One, 129 respondents had completed the survey. Of the participants, 71.6% had a social work qualification and remaining correspondents had a social care qualification. There was almost equal representation from those who had worked in the field of social work or social care for less than or more than 10 years. The survey had 3 main sections which focused on: Perceived Impact of the Agency; Experience of Transition and Views on benefits and challenges of the Agency.

The study was piloted with colleagues from social work and social care and included 54 respondents. As a result of the pilot, some adjustments were made to the schedule. For example, regarding Impact, an initial question asking about perceived impact on quality and Consistency of service was separated and ‘Don’t know’
was dropped on the basis that predicting likely Impact is, in itself, a ‘best guess’ on the information available to date. However, in the survey, about 25% of respondents skipped the ‘Impact’ Questions (Section 1) which may have been due to the lack of a ‘don’t know’ option. Regarding experience of transition, the experiences shared by pilot participants were used specifically as the terminology for this response. The fact that only 6 respondents added an ‘other’ reflects how accurate and comprehensive the pilot candidates’ identification of experience of transition was. Regarding benefits and challenges, the pilot acted as a vehicle for some debate and discussion and it is hoped the reporting of the fuller findings here produces a similar dialogue and openness to exploring the implications of the findings.

As aforementioned, 129 respondents completed the survey by mid-October. Both Quantitative and Qualitative Data was collected and is summarised in the following section. Before presenting the findings, the limits of the study are important to note. It must be emphasised that the response rate, while very positive, cannot be deemed representative of the views of social work and social care members of the respective organisations. Therefore care must be taken when generalising from the findings. As emphasised in the presentation of these findings and in the introduction, this is an early stage of research and it is not intended to offer conclusive outcomes but rather to give voice to some of the views, experiences and opinions of staff who expected to be working both within and outside of the Child and Family Agency (37.5% of respondents were due to be employed in the new Agency; 46.1% were not and 16.1% did not know at that stage if there were going to come under the Agency or not).

While acknowledging that the responses account for only a small proportion of the overall membership of the organisations (and more so, the professions), and the research is preliminary, it remains of interest at this point in time as it gives important insight into and voice to how some practitioners perceive the transition and its potential impact. The next section reports on the main findings and this is followed by a brief discussion, using Bridge’s model of Transition (2002; 2003).

**FINDINGS**

**Perceived Impact of Agency**

The first section of the survey asked candidates to rate their view of perceived impact of the agency on six specific areas that the Agency reforms are specifically concerned with (drawn from the Task Force on Child Care 2012 and the Regulatory Impact Statement, 2013). These were: Improving Quality; improving consistency, enhanced accountability; more effective inter-disciplinary and inter-agency working, greater integration of children’s services and more consistent focus on early intervention. Three options (very much so; to some extent and not at all) were available for each question. A general question about whether the Agency would produce better outcomes for children and family services overall and most of those who responded (63.7%) agreed that it would ‘to some extent’. 12.5% responded ‘very much so’ and 16.7% ‘not at all. As the chart shows, most respondents believed the Agency would have an impact ‘to some extent’ on improving quality (72.6%); improving consistency (72.6%), enhancing accountability (46.9%); ‘more efficient interagency and interdisciplinary working (53.2%); greater integration of children’s services (53.7%) and more consistent focus on early intervention (54.4). It is of interest to note that the largest ‘very much so’ response was for enhanced accountability (30.2%) and the largest ‘Not at all’ was for more efficient inter-disciplinary and inter-agency co-operation (29.8%). The reasons for this are complex with some indications offered in the qualitative findings that follow below.

**Chart 1: Perceived impact of the new agency by all participants**

<table>
<thead>
<tr>
<th>Area</th>
<th>Very Much</th>
<th>Somewhat</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>14.3</td>
<td>53.7</td>
<td>32.0</td>
</tr>
<tr>
<td>Early Int</td>
<td>18.9</td>
<td>54.4</td>
<td>26.7</td>
</tr>
<tr>
<td>Integration</td>
<td>20.0</td>
<td>53.7</td>
<td>26.3</td>
</tr>
<tr>
<td>I-D/I-A</td>
<td>17.0</td>
<td>53.2</td>
<td>29.8</td>
</tr>
<tr>
<td>Acc</td>
<td>30.2</td>
<td>46.9</td>
<td>23.9</td>
</tr>
<tr>
<td>Consistency</td>
<td>13.7</td>
<td>72.6</td>
<td>13.7</td>
</tr>
<tr>
<td>Quality</td>
<td>12.5</td>
<td>70.8</td>
<td>16.7</td>
</tr>
</tbody>
</table>

When one separates the findings between those who were expecting to be in the agency to those who are not involved or did not know, overall, participants expecting to be in the Agency were more certain of the likely impact of most of the factors listed (higher scoring for ‘very much so’) with the exception of more efficient inter-disciplinary and inter-agency working which was more on a par with participants as a whole. About the same % of respondents answered ‘not at all’ to questions regarding impact on integration of services and more effective early intervention.
Finally, in relation to impact, I gave respondents the following statement and asked if they ‘Agreed’, ‘Disagreed’ or ‘Did not know’.

‘The Regulatory Impact Analysis Statement’ (July 2013) referred to earlier outlines that: “There are no direct impacts relating to Jobs, North-South, East-West Relations, Gender Equality, Poverty Proofing, Competitiveness & Industry Costs, Rural Communities, Quality Regulation, People with Disabilities and Human Rights arising from the establishment of the new Agency” . What do you think?’

15.5% agreed, 23.3 % disagreed and 66.6 % responded ‘Don’t Know’. Generally, the statement was deemed too broad and sweeping to be able to determine an affirmative or negative response.

Overall, the impact data gives an interesting snapshot of perceptions of how the Agency will improve and enhance services to children and families. The views on benefits and challenges of the agency summarised below give further insight into the basis for the concerns, challenges and hopes expressed in the responses.

**Experience of Transition to the Agency**

Moving onto the second section of the study, respondents were asked to describe how they were experiencing the transition. As Chart 3 shows, motivation was the lowest ‘experience’ accounting for only 3% of responses. About half of the respondents reported it was having little to no impact while a further third reported their experience as being ‘confusing’.

A breakdown of the responses from all respondents (social work and social care) in the agency as opposed to those outside of agency/don’t know and all social workers and those within the agency gives a more detailed picture of how the transition was being experienced depending on the context of the respondent.

**Chart 4: Further Breakdown of Experience of Change process to Child and Family Agency**

Which of the following terms best describe how you are presently experiencing the change process to the Child and Family Agency?

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Total Response</th>
<th>In agency</th>
<th>Not in agency</th>
<th>Social workers</th>
<th>Social Workers in agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stressful</td>
<td>7.8%</td>
<td>11.8%</td>
<td>4.76</td>
<td>6.35</td>
<td>10.71</td>
</tr>
<tr>
<td>Challenging</td>
<td>10.0%</td>
<td>23.5%</td>
<td>0</td>
<td>12.70</td>
<td>25</td>
</tr>
<tr>
<td>Exciting</td>
<td>6.7%</td>
<td>8.8%</td>
<td>7.14</td>
<td>6.35</td>
<td>10.71</td>
</tr>
<tr>
<td>Confusing</td>
<td>30.0%</td>
<td>35.3%</td>
<td>21.43</td>
<td>26.98</td>
<td>35.71</td>
</tr>
<tr>
<td>Motivating</td>
<td>3.3%</td>
<td>5.9%</td>
<td>2.38</td>
<td>1.59</td>
<td>3.57</td>
</tr>
<tr>
<td>Time Consuming</td>
<td>13.3%</td>
<td>20.6%</td>
<td>7.14</td>
<td>15.87</td>
<td>25</td>
</tr>
<tr>
<td>Having little impact on me</td>
<td>31.1%</td>
<td>14.7%</td>
<td>42.86</td>
<td>34.92</td>
<td>14.29</td>
</tr>
<tr>
<td>It has no impact on me</td>
<td>16.7%</td>
<td>8.8%</td>
<td>21.42</td>
<td>14.29</td>
<td>10.71</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>6.7%</td>
<td>5.9%</td>
<td>4.76</td>
<td>7.94</td>
<td>7.14</td>
</tr>
<tr>
<td>Skipped question</td>
<td>39</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Overall, the findings from Section 2 show that social care and social work professionals are experiencing the transition in a variety of ways depending on their position,
level of knowledge about the changes; perceived views on likely impact and benefits and concerns about implementing policy to practice. The reasons for these experiences are wide-ranging and care should be taken in generalisation. However, the high level of responses of ‘confusing’, while understandable at the beginning of a new system, implies the need for ongoing attempts to disseminate, communicate and engage staff in the transition as a priority. The following section gives some further insight into how practitioners view the benefits and challenges of the New Agency.

**BENEFITS AND CHALLENGES OF THE NEW AGENCY**

In this section of the survey, respondents were invited to identify the benefits and challenges of the New Agency from their perspective without pre-set questions or prompting. The following are main themes, accompanied with illustrative quotes that reflect the main responses.

**Benefits of the New Agency**

The main benefits identified by participants were themed under the following headings:

**STANDARDISATION (18 responses)** “All staff working together with one aim to enhance and support the lives of young people, working in co-operation with other services and joining up the dots between the services that work with children and their families”.

**INTER-AGENCY/PROFESSIONAL RELATIONS (11 responses):** ‘communication between child protection practitioners and other agencies and more willing to engage with other agencies around interventions with child and family’

**DISTINCT IDENTITY (7 responses):** ‘No longer being tied to the bureaucracy of the HSE will hopefully lessen the stress, having a clear management structure will hopefully allow for better communication’; ‘separation from HSE title will have a profound impact’

**BEHOLDER OUTCOMES (4 responses):** ‘overall, the outcomes for children at risk will be improved’

**CLEAR BUDGET: (4 responses):** ‘the budget allocated to children and families will be ring-fenced not used for acute hospital overruns’

**ACCOUNTABILITY: (4 responses)** “it is one agency accountable, managing and working with children and families”.

Other individual responses included improvements in early intervention; service user participation and achieving the best interests of the child.

12 respondents were unable to identify any benefits, and expressed notable concerns as reflected in the following quotes:

‘I have no idea’;

‘I have no confidence’

‘None as I think the Agency is based on a very bureaucratic tick-box model which is geared towards protecting the organisation and continues the disconnect between management and frontline staff who are dealing with very complex families with very limited resources’

‘I would hope outcomes would be better but to be honest children are getting such poor services now it is difficult to see the quality improving in the current climate’

**Challenges and Limitations of the New Agency**

The main limitations identified were themed under the following headings:

**RESOURCES (25 responses)** ‘there is a lot of good will from social workers. However, if it is not resourced adequately it will mean that social workers will be overworked and held more accountable for mistakes which in reality should be the responsibility of management to seek more resources’; ‘Agencies on the ground are very concerned about survival and making more and more cuts’

**INTER-AGENCY/PROFESSIONAL RELATIONS (20 responses)** ‘I am very concerned that all the links and working relationships that have taken years to build up will be broken’; ‘some important parts of HSE will be outside of the agency’; ‘absence of CAMHS, Nurses (PHN) Psychologists will make multi-D work more difficult. Danger that CP will be ‘dumped’ in New Agency’

**BUREAUCRACY (18 responses):** ‘the demand on frontline practitioners to meet agency demands to meet time frames for the Standard Business Practice & other forms including Measuring the Pressure document & the fact that frontline concerns that are passed up are not listened to by senior management’; ‘This type of system is killing social work in the UK’

**PRACTICE AND CULTURE CHANGE: A number of comments were made about the inter-related areas on impact on practice and the need for cultural change in the organisation. These quotes capture some of the diverse comments provided which reflects this theme.**

The main challenge will be to ensure that all levels of staff employed by the agency are signed up to a culture change and actually embrace the new way of working’

‘would like to see more preventative work being done regarding psycho-education and a consultative service for both professionals and the public’

‘Not knowing if the Children’s Rights Referendum is passed yet is a concern’

‘Basic needs are not being met when children come into care…’

‘Complete Transformation is required in which a vision is developed and thorough, and thought out response
to children at risk is provided which ensures that every child in our country is given the optimum chance to grow and have positive life choices.

‘Challenge of ‘broken dysfunctional practices based on little evidence and supported by a not fit for purpose social work education structure in universities…’

While many challenges and concerns were expressed in the responses, interestingly, many responses also alluded to hope for change nonetheless. Indeed, ‘hope’ and ‘hopefully’ recurred frequently in the comments from participants. The statements below illustrate this sentiment.

‘Hopefully more communication…’

‘Hopefully improved focus on inter-agency

‘Hopefully more inclusive of people with disabilities and their families…

‘Hope it will provide a forum which will more successfully integrate new learning and old experience in social work practice’

‘Hope it will be more staff friendly and our voices may be heard more’

‘I would hope it will lead to better partnership…

‘Hopefully lessen the stress, having a clear management structure will hopefully allow for better communication’

Discussion and Conclusion

The BASW Report on the State of Social Work recently published makes it clear that there is no easy way to connect the ‘view from the frontline’ and the complex development and operation of policy at a wider context. For example, the report talks about the potential and inherent expertise amongst practitioners:

‘There is clearly a deep understanding among experienced practitioners about what makes a good service and how to work effectively in securing positive change for people in need. There is also a clear grasp of what newcomers to social work require to be able to practise effectively and of how to balance the proper recording of cases – witnesses repeatedly acknowledged the importance of being accountable for their work – with spending time alongside the children, families and adults who are, ultimately, the reason the profession exists’ (p.9)

But also concluded that:

‘There is scant evidence, however, that this expertise is sufficiently central to policy development and to the allocation of resources’ (p. 9).

This is in some way an inevitable feature of any complex system wherever change is occurring and there aren’t any easy solutions. But this survey of Irish child welfare change does show that what practitioners have to say is gravely important and informative and there is an ongoing need, and responsibility on everyone’s part across the system, to continue to strive for avenues for hearing a range of voices and using the opportunity presented in this change process, notwithstanding the challenges, to genuinely work towards the following ideal outcome of the New Agency, and the spirit captured in the frameworks for assessment and intervention already developed (such as Meitheal) which was simply but eloquently put by one respondent:

“All staff working together with one aim to enhance and support the lives of young people working in cooperation with other services and joining up the dots between the services that work with children and families”

The survey, while initial and non-representative of all social care and social work professionals, has produced some insightful, challenging and hopeful data that offers themes of importance that are being discussed at many levels presently and require ongoing attention as the agency develops over the coming months and years. Inevitably this transition will be phased and gradual; it started long before 2 Jan 2014 and will continue well into the coming months and years. The need for ongoing hope for change is a necessary component of potential success but at the same time, the serious concerns of practitioners need to be listened to. Models of change and transition also emphasise the diverse impact of transition on those involved in it and the need for attention to not only the end goal but also the process of achieving this. Bridge’s model of transition first published in 1991 is a particularly relevant one to consider. This model was adapted by Anghel & Beckett in 2007 to consider organisational change in Romania at that time and further developed by Dima (2012) in her study of the experiences of transition of young people leaving care. Bridge’s model suggests that transition occurs over 3 phases; The Ending Phase; Neutral Zone; and New Beginnings. Dima (2012) adapted Bridge’s second stage of the model from Neutral to ‘In- Between’ in recognition of the many challenges that exist between leaving an existing phase (be it end of care or end of an organisation) and moving to a new phase (be it independent living or a new organisation). Reporting the application of the model to the Leaving Care study, Dima and Skehill (2012) concluded that: ‘Overall, the findings show that socially, care leavers leap directly into the third phase, the ‘beginning’ of a completely new phase in their lives…. while psychologically they still need time to deal with the ending, separation and ‘in-between’ phase, which cannot be accomplished instantly’ (Dima & Skehill, 2012; 2537-2538). Bridge’s model generally emphasises the importance of paying attention to the impact of transition on those most affected by it and from observing the change process over the past 18 months,
his model, insight and framework have resonated with my observations of the current change process from the HSE child welfare services to the New Agency. In this study, the focus is on frontline practitioners as illustrated in Chart 5 but the model, as adapted by Dima (2012) seems as applicable to any other level of the transition or indeed other processes reflecting major change as indicated in the current new system development. This model may prove useful as the transition continues and it will be developed further at each stage of the research.

Conclusion: Adaptation of Bridges Model of Transition (2001; Dima, 2012)

References
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Many thanks to social work and social care colleagues from the Irish Association of Social Workers and the Irish Association of Social Care Workers who participated in the study. Thanks also to those within the associations who assisted in distributing the survey to members.

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INTRODUCTION

Section 3(1) of the Child Care Act 1991 places an obligation and legal duty upon the Child and Family Agency (Tusla) ‘to promote the welfare of children in its area who are not receiving adequate care and protection’. This role is carried out by child protection social workers throughout the State. This research focused on a specific element of this role; specifically the social worker’s responsibility to accept and assess retrospective reports of childhood sexual abuse.

Retrospective disclosures of abuse may be defined as ‘disclosures by adults of abuse which took place during their childhood’ (Department of Health and Children, 1999:39). In 2010 the Ombudsman for Children’s Office revealed that inconsistencies and variable practices existed in relation to child protection practices across the country and specifically in relation to the implementation of the 1999 Children First national guidelines (Ombudsman for Children’s Office, 2010). The central hypothesis of this research was that, due to gaps in Irish policy, these variable practices and inconsistencies still exist, specifically in relation to retrospective disclosures of childhood sexual abuse.

The hypothesis that these variable and inconsistent practices exist in relation to the referral, assessment and management of retrospective disclosures is important firstly because the alleged abusers that may be identified through these referrals may still pose a risk to current children if not appropriately assessed and offered treatment.

Secondly, given the dynamics of child sexual abuse and its impacts in later life, these referrals are being made by a potentially vulnerable section of society who are displaying great courage and strength not just in coming forward to reveal their own experiences but in attempting to stop the cycle of abuse and protect current children. Taking this vulnerability into account the consistent and standardised management of these referrals is of utmost importance.

This research sought to present a contextual background to this area of social work practice, examine and highlight the perceived gaps in both policy and practice and finally speak with the key stakeholders and present their views on the complexity of this situation. Given the statutory obligation placed upon social workers in this area (Child Care Act, 1991) this is a path rife with legal and practice pitfalls and in the absence of clear, detailed, national guidelines or policy social workers are being asked to walk it blindfolded.

CONTEXT OF THE RESEARCH

In 2002 the Dublin Rape Crisis Centre published a report which highlighted that 42 per cent of women and 28 per cent of men have experienced some form of sexual abuse during their lifetime. The most striking statistic presented by this report however revealed that of the 3,120 participants surveyed almost half (47%) had never previously disclosed their experiences (McGee et al, 2002). These statistics are frightening in that they hint at the potential, undiscovered, extent of child sexual abuse within the State.

When read in conjunction with the plethora of institutional and religious child abuse cases reported in the State; the Reps Report (Commission to Inquire into Child Abuse 2009; Commission of Investigation, Report into the Catholic Archdiocese of Dublin, 2009; Commission of Investigation, Report into the Catholic Diocese of Cloyne, 2010; The Ferns Report, 2005), the cases of Kelly Fitzgerald (Joint Committee on the Family, 1996), the Roscommon Child Care Case (Health Service Executive, 2010) and the Kilkenny Incest Case (South Eastern Health Board, 1993) and it would appear that child sexual abuse is at epidemic proportions in Ireland.

The social worker’s responsibility under Section 3.6.1 of Children First 2011, which deals specifically with retrospective disclosures, is to ‘establish whether there is any current risk to any child who may be in contact with the alleged abuser revealed in such disclosures’ (Department of Children and Youth Affairs, 2011:15). This responsibility is in existence, in exactly the same wording, since 1999. Despite the presence of general child protection guidelines since 1987, statutory commissions of investigation since 1993 and specific guidelines concerning retrospective disclosures since 1999, those who participated in this research, including child protection social workers, were of the view that the responses in this area are still insufficient to adequately protect children.

METHOD

Semi-structured interviews following an iterative process were undertaken as part of this research. This meant that the responses to the initial interviews influenced the questions posed in the latter interviews. This approach was suited to the research question in that two of the main stakeholders are separate agencies who deal with different aspects of the issues surrounding retrospective reporting and who would not necessarily have an intricate knowledge of each other’s concerns, difficulties or role. The iterative nature of the qualitative interviews allowed for a conversation, of sorts, to be had between the two organisations specifically relating to issues surrounding retrospective disclosures.
Participants were purposively selected for their experience and responsibility in relation to both assessment and referral of retrospective disclosures. Therefore, interviews were conducted with four Child Protection social workers, three members of staff, in the areas of advocacy and psychotherapy, from the agency One in Four and a former Assistant National Director of HSE Children and Family Services. This iterative approach ensured that while all participants were reflecting upon the same issues each participant was able to offer their own reactions and comment on the input of other participant groups.

KEY FINDINGS

Policy and Practice

Variation in practice arose as an issue across all interviews and related to the practice surrounding the receipt, assessment and management of retrospective disclosures of childhood sexual abuse by child protection social workers.

Staff at One in Four expressed the following concerns in relation to their experiences of interacting with child protection services:

“We should have written instructions around it… I would imagine in terms of dealing with a social worker… you would probably get a varied response depending on who is answering them or who’s is responding to the referral… it’s not even like it’s going to be a universal response.” (Social Worker A)

“But again it is very unclear I’m sure it depends on the team and changes probably from team to team and it is not a standard procedure at all.” (Social Worker C)

The former Assistant National Director of HSE Children and Family Services clarified this situation by talking about how the system looked prior to 2012 and how the effects of that system may still filter through to today’s practice.

“We had 32 community care areas, each were line-managed by a principal social worker, not by the child care manager, but the child care manager has authority over x, y, z. Then you had administrators, a general manager. Then you had a local health manager. You basically had 32 independent republics.” (former Assistant National Director)

One in Four also highlighted the following issues when dealing with social work offices on behalf of those who have experienced childhood abuse; such as the physical location in which an interview with an adult survivor took place and issues surrounding the verification of details:

“…sometimes you are sitting in a play room, which is grand but at the same time, it’s just, given the dynamics of sexual abuse, given the age my client may have been abused at, sitting amongst toys talking about abuse is not always the best” (One in Four)

“We’ve had situations where a social worker refuses to take a notification because we couldn’t give the date of birth of the alleged offender. We have situations where social workers are reluctant to engage with us if we can’t name a particular child and so on and so forth.” (One in Four)

The social workers interviewed acknowledged that there are issues with social work practice surrounding retrospective referrals and this research highlighted personal sensitivity to the situation but professional helplessness in respect of their role and the procedures to be followed.

“The unfortunate bit in that is, you would imagine, the immediate response is that the person that’s come to you to disclose the abuse and is telling you for the first time should be the main focus of that referral, and of course it isn’t, because the main focus when you make that referral to child protection team is who’s the perpetrator, where does he live, do you know any contact he has with children.” “It’s uncomfortable and it doesn’t fit well with the nature of social work and what social work is about and it’s one of the ones that completely highlights how that can be flipped on its head.” (Social Worker A)

From the data which emerged throughout the research it appeared that far from individual practice being an issue there seems to be a wider system-level failure. A theme in relation to social work training struck a chord with all social workers interviewed and developed in to a more specific theme which presented specific issues around the professional guidance that social workers received in relation to retrospective disclosures. A participant from One in Four summed up the situation in relation to issues with social work practice by again hinting at the wider system problem and the guidance that social workers may or may not be receiving.

“I’ve seen some of the most horrendous family cases and I’m not sure if the best social worker in the
world was in that situation that they would have the resources, not as in material wise, but that they would actually have the legislation or just the policy to actually address the situation properly.” (One in Four)

The social workers interviewed echoed these sentiments and spoke of an ultimate lack of guidance and a sense of being adrift within this situation:

“While services and the supports might be there on a community level but if the legislation and policies are not there how can we manage that or how can that be done properly, like we’re the ones delivering it at the end of the day but if the legislation and policies are not there to support… and around it, well that is a big stumbling block for us.” (Social Worker C)

The former Assistant National Director’s response to the above comments seems to highlight a possible disconnect between policy design and aims, on one level, and policy implementation on the ground.

“It doesn’t matter whether it’s yesterday or twenty five years ago it needs to be investigated and then determined whether there is current risks.” “If you have your full resources you will do every single allegation. If you have 80% of staff, if you have 70% of staff, at what point do you prioritise which allegation is going to be investigated? That I think is going to be a critical point, that’s where it’s at.” (former Assistant National Director)

A participant from One in Four spoke of Children First 2011 as a positive development in child protection and policy implementation on the ground.

“Child protection as a system is actually quite tight and quite clear in the procedure with the new business stuff so that is… it is in place for other referrals of another nature it isn’t just in place for retrospective ones, so I can’t see that there is an obstacle in terms of that.” (Social Worker A)

Effects on Adult Survivors

A strong theme that developed throughout all of the interviews was the adult survivor’s experiences of the referral process, what their understanding of the system is and what their expectations are. A participant from One in Four strongly highlighted the presence of misunderstanding when it comes to survivor’s expectations and understanding of the system:

“Some clients that will come to us with the direct intention to make a notification but to be honest that’s rare. People aren’t cognisant, or they’re not aware of the procedures so they don’t ring up saying I want to make a notification because they don’t know that that’s what you do.” (One in Four)

“... you work really intensively with a client building them up, suggesting maybe therapy for a couple of months then coming back, writing out a statement and they’re all gung-ho about what the social worker can and will do and then six months later they haven’t heard a thing and then another six months later, a year later they’re angry.” (One in Four)

“If therapy is about anything for people who have been sexually abused it is about empowering that person to take back their lives and I would see reporting as very much part of that process; the client finding their own voice” (One in Four)

In response to this area Social Worker A clearly highlights the lack of standard procedures in respect to retrospective disclosures of abuse. While Social Worker D adds to this by highlighting a specific inadequacy in relation to the retention of relevant information and external agencies’ accessibility to it:

“Probably the agencies are looking to you to tell them what happens and what the procedure is what does that fit in to, and again they are met with the same response, there isn’t a process or there isn’t a standard bit for it.” (Social Worker A)

“It’s like child protection; we still don’t have a centralized database of children or families that are known to Child protection Services.” (Social Worker D)

An interesting finding under this theme was that fact that each social worker interviewed mentioned the existence of a ‘folder’ in which information regarding retrospective disclosures was kept. Some social workers referred to it as ‘drawer in an office’ or a ‘box’. Irrespective of the receptacle this theme highlighted the complete absence of policy and procedure surrounding the maintenance and storage of information regarding alleged child sexual abusers.

“Well what we are doing with referrals in respect of child abuse is we are literally putting them into a folder and it stays sitting in that folder because, you can say it is about your hands being tied but, it’s about nothing being in place to respond to it.” (Social Worker A)

“It is put in a box or a drawer... and we don’t know what happens it and people don’t know who to share the information with or how do you do it and that’s management like.” (Social Worker C)

“I worry about that because I think that with the best will in the world there’s a brown file in there with an awful lot of names I don’t know if anything is being done with that and I think there are people at risk and it needs to be looked into. The information is there but it’s not being used I don’t think.” (Social Worker D)
DISCUSSION
Policy and Practice Issues
A national review of compliance with Children First conducted in 2008 and the Ombudsman for Children’s report in 2010 highlighted inconsistency, lack of uniformity and ‘variable practices’ within child protection practice. The revised Children First 2011 again sought to remedy these situations and was presented as an edition to ‘supersede all others’ (Department of Children and Youth Affairs, 2011:iii).

It was therefore a significant finding of this research that all of the participants interviewed provided evidence that variable practices are still prevalent within child protection services and specifically in relation to retrospective disclosures of abuse. The findings specifically highlight “massive inconsistencies”, “patchy implementation” and practices that “probably change from team to team”. This is evidence that despite the best efforts of a series of child protection policies in this area practice on the ground remains very much the same.

It is too easy however to suggest that social workers are responsible for these inefficiencies. Children First policy has regressed somewhat, in terms of retrospective disclosures, since its introduction in 1999. The 1999 version contained a paragraph which specifically stated the importance and significance of retrospective referrals in terms of the protection current children (Department of Health and Children, 1999:40, Section 4.6.1).

However, this specific paragraph was not included in the updated version. While the paragraph itself did not add anything by way of practical guidance it did serve as recognition, on a policy level, of the importance of the referrals made by adults who have experienced childhood abuse and its absence serves to echo the state of policy in relation to the handling of retrospective disclosures at present. Social workers are being asked to accept and assess these referrals with very little guidance and this research reflects this.

It is important to note that the findings did show that there has been a general improvement in child protection practice since the implementation of Children First 2011 and a significant element of this, from a social work point of view, is the evidence to suggest that work with adult survivors has become more client-centred. While generalisation cannot be made from such a small sample size this is an endorsement of the high quality work of social work professionals, despite policy failings.

Findings concerning ‘the folder’ and the retention of information on alleged child abusers show that the current lack of guidance and policy is such that social work offices are storing information regarding alleged abusers on an ad hoc basis. This was a finding which was not anticipated by the research and does not fall within its remit. It should be noted that in the interim since this research was conducted the Child and Family Agency has made some progress in relation to this situation. However, it is recommended that further studies in this area examine this practice as it may have implications in terms of Freedom of Information requests and the Constitutional and Human rights of alleged abusers.

A feature which also emerged in this research and relates to the above finding concerning the retention of information was participant comments in relation to the Barr Judgement. The Barr Judgement, as it is commonly referred to, is the judgement of Barr J. in the case of M.Q. v. Robert Gleeson, The City of Dublin Vocational Education Committee, Francis Chance and The Eastern Health Board [1998] 4 IR 85. The judgement specifically dealt with situations where the HSE are in receipt of information concerning alleged abusers and how that information should be used.

Justice Barr stated that there are times when there will be insufficient evidence to establish the presence of the abuse alleged. However, he went on to state that there may be sufficient evidence to form ‘a significant doubt in the minds of competent experienced health board or related professional personnel’ and if such a doubt is formed that it follows that ‘a health board cannot stand idly by but has an obligation to take appropriate action’ in such circumstances.

The HSE’s Child Protection and Welfare Handbook (2011) clarifies this situation for social work practitioners by stating, in specific reference to the Barr Judgement, that ‘the HSE has a statutory duty to investigate all allegations of abuse and assess what potential risk if any the alleged perpetrator may pose to children’ (Health Service Executive 2011:145). The handbook goes further than this to outline the fact that ‘the duty of the HSE is not limited by the fact that a disclosure is made by an adult of abuse suffered during their childhood since the HSE’s duty includes the prevention of future risk’ (Health Service Executive, 2011:146). Despite this clarification the findings of this research suggest that confusion and inconsistent practice pervade in relation to the retention of this information and in relation to the interpretation of the Barr judgement.

Effects on adults who disclose to child protection services
This research highlights that the process by which adults refer their experiences to child protection services is rife with inconsistency, misunderstanding and confusion and that these factors may present barriers to adults making referrals. This suggests the system itself as a potential deterrent to referral and warrants further study. The social workers who participated in this study also acknowledged this feature and voiced their concerns and unhappiness with it.

‘Adults who experience sexual assault in childhood are present in all parts of the health and welfare systems both as clients and as staff. However, these systems can mirror and maintain the larger social denial of the prevalence and impact of violence towards women and..."
children, including childhood sexual abuse’ (Gibbons, 1996:1755).

Conclusions
Data collected during interviews with the child protection social work practitioners highlighted their unhappiness with the current practice surrounding retrospective referrals. All social worker participants called for greater clarity in the area and further guidance from their management. Despite the updating of Children First (Department of Children and Youth Affairs, 2011) and the subsequent publishing of the Child Protection and Welfare Handbook (Health Service Executive, 2011) it is clear from this research that confusion remains.

It is acknowledged that some areas social work offices are being proactive about this situation and designing their own standardised responses to retrospective disclosures of abuse (Quinlan & McLoughlin, 2012) however this is on an office-by-office basis which threatens to echo the confusion and variable practices of the past (Department of Health and Children, 2008; Ombudsman for Children, 2010; Department of Health, 1999).

Social workers, through their training, are professionally equipped to deal with traumatic situations and vulnerable individuals. All participants agreed that child protection social workers are the profession best placed to deal with retrospective referrals and this research has highlighted that, with proper detailed guidance and training, the participant social workers indicated a willingness to fulfil this role.

This piece of research aims to fill part of a large gap in academic literature designated for practice in relation to retrospective disclosures. It provides a general overview of a very specific issue and in doing so aims to provide social work practitioners with some guidance and reassurance that, far from social work practice being the problem in this area, there is a much wider system-level failure to meet the needs of adult survivors, current children and alleged abusers alike.

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About the Author
Joseph Mooney is a professional qualified and CORU registered Social Worker having attained a First Class honours Master Degree in Social Work from the National University of Ireland, Galway in May 2013. Prior to this Joseph attained an honours LLB Degree in Irish Law in 2005.
Joseph joined the Child and Family Research Centre in October 2013 as a doctoral researcher under the supervision of Professor Caroline McGregor. Joseph’s main area of research concerns the experiences of adult survivors of child sexual abuse when disclosing to child protection social work services.

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INTRODUCTION

Social workers’ priorities and requirements regarding Psychology service provision remains under-researched. The referral process between social workers and psychologists is of key importance as social workers are amongst the most frequent agents of mental health and psychological referrals (Gant et al, 2009). Previous research into referrals from social workers to Psychology services in Ireland has focused on both referral frequency, and the predictors of referral frequency. Hughes et al. (2013) found that social workers were the source of 9% of all referrals to a primary care Psychology service in Ireland. A multiple regression analysis undertaken by Ryan et al. (2013) found that the theory of planned behaviour predicted 16% of the variance in referral rates by social workers to Psychology services in Ireland. The findings of the study by Ryan et al. (2013) indicated that approximately one-sixth of the variance in referral rates could be explained by the following three factors: social workers’ attitudes towards referring to Psychology; subjective norms regarding perceived frequency of referrals by other social workers to Psychology; the perceived level of control social workers had regarding making the referral.

However, the specific needs and expectations of social workers when making referrals to Psychology services have yet to be explored. Research has previously been undertaken on the needs and expectations of other health care professionals when referring to Psychology services in Ireland, such as the range of patient presentations where Psychology input with child and family services would be most welcome. The current study aims to extend previous research by exploring the needs and expectations of social workers when referring to Psychology services in Ireland, and by ascertaining what additional services Psychology departments could provide to meet those needs.

METHOD

Fifty one Health Service Executive (HSE) staff participated in an anonymous online survey. 45 social workers and 6 social care/child care workers participated. The total number of staff invited by email to participate was 486, which consisted of staff from HSE departments in each HSE region nationally. The response rate was 10.5%. Of the 51 staff that responded, 48 were included in the study as they worked in the area of child and family services (including child protection services, child welfare services, or children in care services). Recruitment was undertaken by initially contacting the Principal Social Workers in HSE departments throughout Ireland. Social Work departments were invited to email the online survey to all members of staff, and to subsequently notify the researcher of how many staff members were sent an email invitation. Ethical approval for the study was obtained from the Ethics Committee of the School of Psychology, National University of Ireland, Galway. An online questionnaire was developed to collect data regarding the following questions:

- Proportion of staff that would like a Psychology team member to visit their place of work regularly to provide consultation.
- Proportion of staff that would like to see a Psychologist attached to their team on a full-time basis.
- Social workers’ ranked priorities in terms of the forms of child and family services offered by Psychology.
- Social workers’ ranked priorities for clinical presentations where Psychology input with child and family services would be most welcome.
- Extent to which social workers restricted referrals to Psychology because of a lack of confidence in the Psychology service.
- Extent to which social workers restricted referrals to Psychology due to the expectation of an excessively long Psychology waiting list time.
- Extent to which social workers would like more training in managing psychological problems.

A copy of the questionnaire may be obtained from the authors upon request.

RESULTS

68.6% (n=35) of staff reported that they would like a Psychology team member to visit their place of work regularly to provide consultation. 92.2% (n=47) reported that they would like to see a Psychologist attached to their team on a full-time basis.

Social workers who worked in child and family services (including child protection, child welfare, or children in care services), rank ordered their priorities in terms of what Psychology services should offer (1=highest priority, 6=lowest priority). The highest priority for social workers was the provision by psychologists of direct intervention sessions with children and/or their parents (see Table 1).

Table 1: Social workers’ ranked priorities for Psychology child and family service provision.

<table>
<thead>
<tr>
<th>Ranking</th>
<th>Form of Service Provision</th>
<th>Average Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Direct intervention sessions with children/parents</td>
<td>1.94</td>
</tr>
<tr>
<td>2</td>
<td>Assessment sessions (general)</td>
<td>2.33</td>
</tr>
<tr>
<td>3</td>
<td>Assessment and intervention for parenting/attachment issues</td>
<td>2.52</td>
</tr>
<tr>
<td>4</td>
<td>On-site consultation to social workers</td>
<td>4.20</td>
</tr>
<tr>
<td>5</td>
<td>Group intervention sessions</td>
<td>4.33</td>
</tr>
</tbody>
</table>
Social workers employed in child and family services ranked the clinical presentations with which they would most welcome input from a psychologist (1=highest priority, 16=lowest priority). The highest priority for social workers was input from psychologists with children who were experiencing emotional abuse (see Table 2).

Table 2: Social workers’ ranked priorities for clinical presentations where Psychology input with child and family services would be most welcome.

<table>
<thead>
<tr>
<th>Ranking</th>
<th>Clinical Presentation of Child</th>
<th>Average Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Emotional abuse</td>
<td>2.78</td>
</tr>
<tr>
<td>2</td>
<td>Sexual abuse</td>
<td>4.69</td>
</tr>
<tr>
<td>3</td>
<td>Conduct disorders</td>
<td>5.21</td>
</tr>
<tr>
<td>4</td>
<td>Depression</td>
<td>5.21</td>
</tr>
<tr>
<td>5</td>
<td>Anxiety</td>
<td>5.56</td>
</tr>
<tr>
<td>6</td>
<td>Psycho-educational assessment</td>
<td>5.71</td>
</tr>
<tr>
<td>7</td>
<td>Physical abuse</td>
<td>6.03</td>
</tr>
<tr>
<td>8</td>
<td>Self-esteem</td>
<td>6.85</td>
</tr>
<tr>
<td>9</td>
<td>Grief &amp; bereavement</td>
<td>6.90</td>
</tr>
<tr>
<td>10</td>
<td>ADHD</td>
<td>7.66</td>
</tr>
<tr>
<td>11</td>
<td>Parental separation</td>
<td>7.78</td>
</tr>
<tr>
<td>12</td>
<td>Drug misuse</td>
<td>9.00</td>
</tr>
<tr>
<td>13</td>
<td>Eating disorders</td>
<td>9.52</td>
</tr>
<tr>
<td>14</td>
<td>Sleep problems</td>
<td>11.57</td>
</tr>
<tr>
<td>15</td>
<td>Somatic presentations</td>
<td>12.35</td>
</tr>
<tr>
<td>16</td>
<td>Toileting</td>
<td>13.47</td>
</tr>
</tbody>
</table>

Participants were asked to indicate the extent to which they restricted their referrals to Psychology because of a lack of confidence in the Psychology service, on a 5-point likert scale (1 = always, 2 = often, 3 = sometimes, 4 = rarely, 5 = never). The mean response was 3.94 (SD = 1.07), with a median response of 4. This indicated that, on average, social workers “rarely” restricted their referrals due to a lack of confidence in the service provided. 72% (n=36) indicated that they “rarely” or “never” restricted referrals due to a lack of confidence in Psychology, while 12% (n=6) “always” or “often” restricted referrals for this reason.

Participants were asked to indicate the extent to which they restricted their referrals to Psychology due to the expectation of an excessively long Psychology waiting list time, on a 5-point likert scale (1 = always, 2 = often, 3 = sometimes, 4 = rarely, 5 = never). The mean response was 3.02 (SD = 1.25), with a median response of 3. This indicated that, on average, social worker “sometimes” restricted their referrals due to an expectation of excessively long Psychology waiting times. 36% (n=21) indicated that they “rarely” or “never” restricted referrals due to an expectation of excessively long Psychology waiting times, while 44% (n=21) “always” or “often” restricted referrals for this reason.

Participants were asked to indicate the extent to which they would like more training in psychological problems, on a 5-point likert scale (1 = much more, 2 = a good deal more, 3 = some more, 4 = a little more, 5 = no more). The mean response was 2.42 (SD = 0.76), with a median response of 2. This indicated that, on average, social workers would like “a good deal more” training in psychological problems. 53% (n=27) indicated that they would like “much more” or “a good deal more” training in psychological problems, while 8% (n=4) would like “a little more” or “no more” training in this area.

DISCUSSION

This study explored the needs of social workers regarding Psychology provision in child and family services in Ireland. Social workers were virtually unanimous in their desire to have a psychologist working full-time on their team, with a significant majority also reporting a wish for regular consultation visits from a psychologist. The latter was congruent with social workers also reporting a desire for significantly more training in managing psychological problems.

When making referrals to Psychology, the five childhood presentations that social workers desired most input from psychologists were in rank order: emotional abuse; sexual abuse; conduct disorders; depression; and anxiety. While it is beyond the scope of the present study as to reasons why input was desired most for emotional abuse, it may be that staff who work with children experiencing emotional abuse may require help defining the threshold for determining the presence or absence of emotional abuse.

The form of service provision in greatest demand was direct psychological intervention sessions with children and families. These indicated priorities are in-line with evidence-based practice that supports the effectiveness of psychological interventions (e.g., family therapy, parental training, and psychological therapy with children) for the following presentations: child abuse and neglect; emotional problems (including anxiety, depression, grief, bipolar disorder and suicidality); conduct problems (including childhood behavioural difficulties, ADHD, delinquency and drug misuse); eating disorders (including anorexia, bulimia and obesity); somatic problems (including enuresis, encopresis, recurrent abdominal pain, and poorly controlled asthma and diabetes); and sleep, feeding and attachment problems in infancy (Carr, 2009).

Social workers reported that they rarely restricted their referrals to Psychology due to a lack of confidence in the service they provided, but sometimes did so due to an expectation of excessively long waiting times for an initial assessment. This finding may reflect there being an inadequate number of psychologists working within our child and family services. It may also indicate a need for Psychology services to operate more efficiently (e.g., stepping back from intervening directly in cases and providing more case consultations) and/or their need to use wait list prioritisation criteria that will result in a higher priority assigned to cases referred from social workers (e.g., Hughes et al. 2013). Such issues may be addressed with the recent establishment of the Child and Family Agency.
A limitation of this study was the small sample size, and this restricts the generalisability of the findings. Future research in this area would be enhanced by an increased sample size and an improved response rate. Despite this, the current study represents an important contribution to the research literature as it is the first time a study has profiled the needs of social workers regarding Psychology provision in child and family services in Ireland. Findings indicate that Psychologists need to provide a more responsive service to social workers, possibly by increasing the number of Psychology posts and/or by their working in a different manner.

References


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Child care policy strongly advocates for the voice of the child to be represented in all assessments concerning the protection and welfare of children. This study examines social work education and training in Ireland with regard to the acquisition of age-appropriate communication skills to engage with children. The theoretical base for the study examines four core themes: play and play therapy; attachment theory; child protection and welfare social work practice; and social work education. This research was designed to investigate the role of play in supporting communication between children and social workers during child protection and welfare assessments. There is a wide range of research that maintains play is the language of children and the most effective way to learn about children is through their play. Basic play skills involve using creative age-appropriate means to communicate with children at a pace that is comfortable for them. This study employs a training strategy called the Play Skills Training (PST) programme, designed by the author, which addresses the importance of play skills and the role they occupy in communicating with children about deeply personal and sensitive issues. One of the primary arguments underpinning this research is that social workers need to be skilled communicators to engage with children at risk of abuse and/or neglect.

The study makes an original contribution to knowledge by providing an account of the experiences of a team of child protection and welfare social workers in their use of a PST programme designed to support their engagement with children during assessments. A mixed method approach was used to collect data. The main qualitative study, which was set in a Child and Family Social Work Department in Ireland (Roscommon), provides testimonial evidence of the views of practitioners (n=9) regarding the material delivered on the training course and its applicability to assessment procedures (home visits, investigative interviews and direct work); social work students and a focus group of social workers also provided necessary data on the PST programme and social work training. The quantitative study establishes the collective views of practitioners (n=122) throughout Ireland on current assessment procedures for children and the potential use of play skills in the assessment process. In addition, it captures the views of veteran social work practitioners in relation to social work training and practice in Ireland.

The study highlights the importance of using play skills as an age-appropriate medium to communicate with children in relation to their experiences of abuse and/or neglect. The wider objective of the study is to enable knowledge that will ultimately contribute to better conditions for children, whereby they will experience a child-friendly service where social workers can build relationships with them to ensure their voice is represented in assessments of their well-being and future care options. The major findings are summarised below:

The majority of social workers did not feel that they had received adequate skills to communicate with children during their pre-qualifying social work education.

The majority of social workers did not feel they had received adequate skills to communicate with children from the training they received from their employers. This was highlighted as a barrier to engaging in child-centred direct work with children involved in the child protection system.

After engaging in 20 hours of play skills training, practitioners valued and used the skills in their practice. Data gathered from the participants who undertook the PST training found that the use of play skills in assessments with children supported their practice in 10 different ways: 1) they were more aware and committed to providing a child-friendly environment when meeting with children; 2) they experienced an increase in confidence around engaging with children; 3) they found the assessment process was more child-friendly; 4) the voice of the child received greater representation; 5) they felt more enthused about their work; 6) they used their time with children differently; 7) worksheets designed to explore feelings and experiences were the preferred tool to communicate with children; 8) they engaged in and/or observed children’s play during home visits; 9) communication was enhanced during direct work; 10) communication was enhanced during investigative interviews.

Social workers flagged direct work as a key function of social work practice, but highlighted that due to heavy caseloads and time constraints, they were not actively engaging in the work. It appears from the data that all other elements of the assessment are prioritised above ‘building relationships with children’, which could offer a true picture of their world in a child-friendly manner. Social workers highlighted that the allocation of resources to facilitate their engagement with children using a child-centred approach was minimal. Their departments lacked child-friendly play spaces and the relevant materials to conduct such work.

The data show that play skills are perceived as an important tool to engage with children when exploring complex and sensitive issues around abuse and/or neglect.

Veteran social workers agreed that social workers in child protection and welfare need specific skills to communicate with children about complex issues to ensure they are meeting their needs and believe that practitioners and children can experience difficulties in communicating with each other.
The conclusion of this study is that social workers need to use play skills to build relationships with children in order to gain an insight into their world and to communicate with them about painful and sensitive issues to ensure their best interests are met. This study has found that social workers want to engage in this work with children and they need training, resources and encouragement from their managers to prioritise child-centred direct work during child protection and welfare assessments. This study is an example of evidence based research and the results show that the child protection and welfare system in Ireland would experience positive developments if social workers were to use play skills to engage with children around issues of abuse and/or neglect. Child protection and welfare social workers have a statutory duty to protect children who may be at risk of abuse and/or neglect. It is crucial that they are equipped with the necessary skills to communicate with children about their care and development. There is a need to adopt a child-centred approach when intervening in the lives of the children the service has been established to protect. Embedded in policy, legislation and contemporary regard for children is the child’s right to participate in assessments of their own well-being and future care. Every child has the right to express their views and opinions and to have these taken seriously by their social worker. Children must be active participants in the assessment process and be kept up to date, in an age-appropriate manner, of the status of their case. It is crucial that practice procedures prioritise building relationships with children who are at risk of significant harm.

About the Author

Lisa O’Reilly is a social worker and a play therapist for children involved with social work services in the Child and Family Agency in Co. Roscommon. She has over ten years experience working with children and other client groups using playful and creative means to support the expression of feelings and experiences. During Lisa’s social work and play therapy training she found the greatest self-awareness and ability to express her feelings occurred and developed through creative and playful experiences. After working as a child protection and welfare social worker for a few months Lisa found the verbal interview process to be a difficult experience for children and did not feel she was gaining an adequate insight into their world to ensure their safety and protection. She did a diploma in play therapy and found the developments that took place in her work with children to be monumental. Lisa experienced children to be more accepting of her involvement in their lives; were able to communicate their world in a child-friendly manner; they asked when they could meet with her again and most importantly they had a positive experience of a process which usually involves stress and pain for families. Lisa felt so passionate and enthused by this approach that she commenced her PhD to explore this further.
INTRODUCTION

Primary Care – A new direction (Department of Health and Children, 2001a) was the policy document which outlined in detail the primary care service envisaged by the Irish government under its Health Strategy (Department of Health and Children, 2001b). The document listed social workers as members of the core primary care team, along with other professionals such as general practitioners, occupational therapists and home helps. A limited body of international research has highlighted the key role played by primary care social workers in addressing the psychosocial problems experienced by patients (Bikson et al., 2009; Gross et al., 1996), with at least one study providing evidence that increased social work interventions ultimately resulted in fewer physician visits (Rock and Cooper, 2000). However, little is known about primary care social work within the Irish context.

This article is based on an exploratory study conducted with primary care social workers in 2011-2012. The study arose from discussions at a workshop on primary care social work at the AGM of the Irish Association of Social Workers (IASW) in 2011. Practitioners identified the need for research to be conducted in this area. The research was an exploratory study aiming to gather some basic information about the role of the primary care social worker in the Irish context. The study was approved by UCD’s Research Ethics Committee and by the Health Service Executive. It was an unfunded study which comprised of two phases. In the first phase questionnaires consisting of both open and closed questions were distributed to eighty primary care social workers, using a list provided by the IASW’s special interest group on primary care social work. Forty five questionnaires were returned, thirty-eight from basic grade social workers and seven from respondents who indicated that they were team leaders/principal social workers. In the second phase, a focus group with primary care social workers was conducted. In this article we consider several findings arising from the research, including social workers’ expectations about the role versus the reality, multi-disciplinary work, issues regarding child protection and line management issues. Other findings and a review of the literature on social work in primary care have been discussed elsewhere (Ní Raghallaigh et al., 2013).

STUDY FINDINGS

Initial Expectations about the Role of the Primary Care Social Worker

The social workers in primary care were generally well experienced practitioners, with 75.6% of questionnaire respondents qualified for four years or more. When asked why they had opted for working in this area, there was a mixed response. Some were transferred into the post, were allocated to it from a panel or had moved to primary care for personal/pragmatic reasons. However, for many, it had been a decision related to the perceived value of the social work role in primary care. Reasons given by respondents related to the attractiveness of working with a wide range of clients, who were voluntarily seeking a social work service. Being part of a multidisciplinary team was a further positive feature of social work in primary care.

To work with a broader group of service user; to work with people who wanted a service; to be more creative and autonomous in my work.

Moreover, primary care social work was expected to provide the opportunity for preventative practice and to use a range of methodologies in their work.

I wanted to provide intervention at an early stage, especially to people who cannot access other services as their ‘need’ does not meet the criteria of other services.

The Reality of the Work

In terms of how the reality matched the anticipation, the primary care social worker respondents certainly had a varied caseload. In the questionnaire, respondents were asked to select the client issues that were relevant to their current case load using a list of 15 named issues. Forty five responses were provided. These showed that on average the respondents were addressing 11 different issues within their case loads. These issues ranged from bereavement and difficulties coping with physical illness to domestic violence and parenting difficulties. The most frequently ticked boxes were financial difficulties (selected by 93% of respondents (n=42) and loneliness and isolation (selected by 91% of respondents (n=41)). Where there were issues relating to child protection, the case was automatically referred on to children and family services, and this was often the case in situations of suspected abuse of older people. Also, primary care social workers typically did not deal with clients who were already in contact with another social work agency or who had been referred for purely financial and/or
social welfare issues. Social workers listed the following examples of referrals they did not deal with:

Requests for housing, where there is no secondary need, requests for financial assistance, mental health and child protection referrals.

....referrals relating to elder abuse; referrals when the client is already linked with a secondary service; referrals re financial/social welfare issues.

Having a role that was not clearly defined enabled them to make it their own, even though this involved juggling with the myriad of tasks they could usefully do.

There was nobody to tell you … this is what you have to do. I had a job description which was the length of my arm so my Transformation Development Officer at the time dictated a lot of the work that I started off doing. I had no expectations as I didn’t really know what it was… my expectation was that I would be a generalist social worker working with populations of people with different types of issues, to this day I am still doing this type of work.

Varied Interventions

This resulted in quite a variation regarding how they prioritised their workload. Some engaged almost exclusively in direct work with clients who had been referred or self-referred, seeing themselves as caseworkers in a generic, community-based setting. Others incorporated, or planned to incorporate, groupwork in their practice. The range of groupwork undertaken was impressive in its scope, including issues such as health related support, recovery-oriented mental health, healthy eating, anxiety/stress management, antenatal care, parenting, support for carers and women’s groups for ethnic minority women.

I believe groupwork is an integral part of primary care as it allows prevention, early intervention and, over time, could build capacity and resilience in communities...

The primary care social workers also involved themselves in a range of community work and community development activities. Typically these focused on engagement with community organisations, formal and informal, in relation to assessment of need and developing preventative intervention. Examples of such activities included participating in health promotion events; working with groups such as the Roma community; involvement in parenting forums; community capacity building and assessment of community needs.

Attending local network meetings – input about my role; communicating/discussing issues with local council about problems on [the] new estate for older people.

I liaise with local community groups & sometimes assist them in setting up groups for which there is an identified need or give training / information to specific existing groups.

Such engagement reflected the value of an area based service that can be adapted, to some extent at least, to the needs of the local community. It was evident, for example, that the role would vary depending on whether the primary care social worker's catchment area was primarily urban or rural. In addition, the demographic profile would influence the worker’s caseload and how it might be prioritised. In this way, primary care social workers demonstrated a true generic approach of a community-based system, much as had been envisaged for the original community care social workers in the early 1980s, albeit excluding certain categories such as children and older people at risk.

You’re not specialist in any area, you’re an expert in everything but you specialise in nothing, that to me is what describes primary care social work.

We have quite a lot of flexibility and autonomy in our roles, being able to set up groups, being able to do health promotion, being able to get involved with schools, go out and do presentations, being able to set up plans with 45 agencies, being able to do group work, community work and individual work with clients

At the same time, there was clearly the danger that, given the broad canvas and limited resources, primary care social workers may gravitate to the work that they find the most satisfying and that fits with their practice strengths, rather than what is necessarily the optimum service best suited to the diverse needs of their client population. Indeed, when asked about the extent to which they engaged in groupwork or community work, of the 44 individuals who responded, 36% (n=16) never engaged in groupwork, while 20% (n=9) never engaged in community work. For those who did engage in groupwork and/or community development, there was the ever present possibility that this element of the work could be compromised by the increasing demands of their caseload.

At present the caseload is manageable. If it was to increase over time I would have to sacrifice my community activities to accommodate this. Management prioritises cases over community work.

Participation in Multidisciplinary Teams

Within their positions as primary care social workers, both the basic grade social workers and the team leaders / principal social workers who participated in the research identified a number of conditions of their work that impacted on their capacity to meet the needs of their clients.

The first of these related to team work. As has been mentioned above, the opportunity to work on a multidisciplinary team was something that attracted participants to the primary care role. Within their role, participants saw the benefits of team work, including the sharing of information and being able to learn from other professionals. However, many of the respondents also
expressed frustration about the reality of multidisciplinary practice. Reference was made to the fact that while social workers were supposed to be working within a team environment, in many respects the level of teamwork was questionable. A number of points were made in relation to this.

To begin with social workers were often allocated to work with a number of different teams – networks – rather than being on just one team, as the primary care strategy had envisaged (Department of Health & Children, 2001a). Of the basic grade social work respondents, 84% (n=32) were attached to more than one team, with 10 of these attached to more than three teams. Unsurprisingly, this led to their service being ‘diluted’, with social workers serving very large populations. For example, one focus group participant stated that she was serving a population of 50,000 people. Being ‘ thinly spread ’ across a number of different teams left less time for collaboration and meant that caseloads were high, thus threatening the social worker’s capacity to engage in group work and community work, a point that has been eluded to earlier. Difficulties with collaboration were further compounded by the fact that teams were often not co-located. When asked about the key challenges facing primary care social work, one respondent stated:

[The challenge of how to] maintain a ‘team’ feeling due to being on different teams and therefore not always on site and team members all based in different buildings / areas – no dedicated primary care team building / settings .

Another stated:

In the context of working with multiple teams, establishing relationships is a key challenge. A secondary challenge is defining the role of the social worker in the team.

Similarly, another respondent who was working across three primary care teams mentioned the difference between being co-located and being located separately:

I am based in the same building as two of the primary care teams. The team that I am not based with I feel operates differently and have referred less to the social work service.

Whether teams were co-located or not, in most cases team meetings occurred. Out of forty four responses, forty respondents – 91% - indicated that team meetings were held either once a month or more regularly. These meetings provided opportunities to share relevant information, to discuss client needs from different professional perspectives, to plan interventions, to take referrals and to provide support to one another. In some instances they also acted as a forum for presentations. However, the majority of respondents indicated that some professionals were frequently absent from team meetings. GPs were identified as one of the professionals who were frequently missing. In the focus group, there were mixed experiences of GP involvement, with one participant stating:

We don’t have GPs at meetings, they don’t attend, they’re running as [they] were before primary care teams came into effect... GPs don’t attend at all, they’ve just withdrawn.

Given the central role played by GPs in community based health care, it was not surprising that a lack of GP involvement had an impact on how teams operated, leading to frustration among social work professionals. Where GPs were participating in the primary care teams, many social workers had very positive experiences of their involvement.

While clearly team meetings had their benefits, their occurrence did not always ensure that team members worked in a collaborative way. Some participants suggested that the disciplines often did not work as a team in relation to clients. Instead, individual workers took responsibility for specific clients. This might partly be explained by the issues arising from a lack of co-location and from the fact that social workers were serving multiple teams. However, it also seemed that it arose from the fact that many professionals were not used to working as a team. Therefore, a shift in professional practice was necessary, but this was challenging. One participant stated:

Primary care teams have been formed, but little work has been done to promote multi-disciplinary work nor has training been provided to this end to benefit the teams.

In some instances social workers felt that the more complex cases were ‘dumped’ on them as nobody else saw it as their role to provide a service in these situations. Multidisciplinary work was also challenged by the lack of understanding of the role of the social worker. At times, this lack of understanding led to inappropriate referrals, including referrals of child protection issues.

Role Issues in Relation to Child Protection

However, practitioners were also given child protection work in a more formal and organised manner, by members of their own profession. Participants frequently raised the issue of primary care social workers being drawn into the work of child protection teams. Of the thirty eight basic grade questionnaire respondents, 32% (n=12) indicated that they were involved in work on the fostering or child protection teams (fostering assessments, duty, etc). All respondents were asked an open question regarding the key challenges facing primary care social workers. Of the forty five responses to this question, almost half (n=22) made reference to challenges relating to child protection: either the threat of redeployment, the pressure to take on some child protection responsibilities along with the primary care role, or the priority given to child protection above primary care. In addition, other respondents mentioned these issues in their responses to other questions. In
some respects, it seemed that while other professionals at times ‘dumped’ cases on primary care social workers through inappropriate referrals, there was a sense that the problem of under resourced child protection teams was also being ‘dumped’ on primary care social workers by social work management. In the context of child protection crises and resource limitations, it seemed that, often, little importance was attached to the primary care role, nor to the needs of the clients and communities served by these social workers. One questionnaire respondent stated:

[The] lack of staff in child protection puts primary care social work at risk of loss of posts because management do not value what we do and child protection is always prioritised over other areas of social work service provision.

A focus group participant stated:

There is a huge threat that I could be moved because [child protection] are down 10 basic grade social workers ... so there is always that threat there.... I wouldn’t be replaced at all. I mean my colleague was given a day’s notice to move form primary care to child and family services. She asked for half a day just to contact her clients to let them know that she was being moved and she wasn’t even given half a day.

Line Management and Supervision

Related to the concern about being drawn into child protection work, was the absence of a line management structure within primary care social work. While the majority of participants were in receipt of regular supervision, two basic grade social workers were not. Of the remaining thirty six basic grade social work respondents, eleven were being supervised by principal social workers or team leaders who were based on child protection / child welfare teams or on mental health teams. In addition, of the seven questionnaire respondents who indicated that they were team leaders or principal social workers, four were supervised by principal social workers from child protection / welfare teams. In the cases of those supervised by child protection and welfare personnel, it was felt by some that because of the pressure on these individuals, there was a tendency to draw their primary care social workers into child protection responsibilities. In situations where specific primary care team leaders were in place, they were able to act as gatekeepers: “as a barrier to stop child protection”.

There were also other challenges that arose from the lack of a clear line management structure. For example, some social workers felt that their line managers did not have an adequate understanding of their role, thus leading to inevitable difficulties for all involved. One social worker who was supervised by a principal social worker who was not based in primary care stated in the focus group:

Their knowledge of primary care would be very limited. My supervisor would say to me that she’s learning an awful lot more from me than I’m learning from her.

In addition, the absence of a line management structure specific to primary care social work meant that there were few promotional opportunities for social workers working within primary care. Several participants mentioned the fact that they were employed as basic grade social workers but that they were doing the work of senior social workers. In describing how primary care social work would look like in an ideal world, one social worker stated:

All seniors, formal clinical supervision, a career structure...

CONCLUSION

It is evident from the findings that social workers in primary care are engaged with a range of clients who hitherto would have had no access to a social work service. Given that the service is generic, community based and can be responsive to the needs of different communities, there are very positive aspects to this relatively newly developed role. To quote one respondent:

I see this (primary care social work) as a move back to what social work sees itself as – accessible, local, empowering, strengths based, non pathologising, systemic.

However, the development of primary care generally, and specifically the provision of primary care social work, has been curtailed by the economic crisis and its aftermath. Moreover, the pressures on services to children and families, has resulted in actual or potential pressure on primary care social workers to move, wholly or in part, to working in the area of child protection. Added to this, is the challenge of establishing the primary care social work role within the multidisciplinary team, particularly in a context where such teams are not always fully formed and functioning at an optimal level. Thus, the study findings offer insight into a new and evolving social work role. As one respondent put it:

If primary social work is permitted to develop, it will be a fabulous post to work in.

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NORTH DUBLIN PRIMARY HEALTH CARE SOCIAL WORK
SOCIAL JUSTICE RESEARCH PROJECT

By Alison Duggan

“The good we secure for ourselves is precarious and uncertain until it is secured for all of us and incorporated into our common life”

Jane Addams.

INTRODUCTION
Social justice emphasises diversity, difference, and structural disadvantage (Ife 2010: 82). It is the view that everyone deserves equal economic, political and social rights and opportunities (NASW 2014a). This article describes a small-scale social justice research project carried out with the advice and expertise of the North Dublin Primary Health Care Social Work team. The project aims to: identify the most vulnerable groups of clients of North Dublin Primary Health Care Social Work due to gaps in service provision and cuts to services and social payments; to generate further awareness about these economic austerity-related inadequacies; and encourage social work advocacy for better resourced services and fair payments. First the relationship between social justice and the social work profession is illustrated, second ‘at risk’ groups of clients of North Dublin Primary Health Care Social Work are identified, and third recommendations are offered.

SOCIAL JUSTICE AND SOCIAL WORK
The International Federation of Social Workers (2014) defines social work as a profession in which ‘principles of human rights and social justice are fundamental’. It has been argued that human rights and social justice serve as the motivation and justification for social work action (IFSW 2014). Social work practice addresses the barriers, inequities, and injustices existing in society (IFSW 2014). It is a pragmatic profession intended to help clients address their problems and match them with the resources they need to lead healthy and productive lives, and supporting this practicality is a strong value system for social justice (NASW 2014). Payne (2010) maintains that social work makes three distinct contributions to social justice: social work uniquely intends to improve relationships between people individually and collectively; social workers endeavour to not give up on people just because they do not fit in with bureaucratic categories; and social workers have always been prepared to intervene in social relations sometimes not gaining them popularity.

CORU (2011: 5) calls on all social workers to promote social justice in practice, through: challenging negative discrimination and unjust policies and practices; advocating for the fair distribution of resources based on identified levels of risk or need; and working towards social inclusion. Social workers can apply social justice principles to structural problems in the agencies in which they work, for example suggesting changes to protect clients who are often powerless and underserved (NASW 2014a). In a more macro perspective, social work interventions can include engaging in social and political action to impact social policy, planning, and development (IFSW 2014). More specifically to Primary Health Care, Fildes and Cooper (2003: 4) propose that a role of the Primary Health Care Social Worker is community development and capacity building. Community Workers’ Co-operative (2014) identifies the task of community development as the achievement of social change linked to equality and social justice. CWC (2014) also maintains that ‘workers have a responsibility to challenge the oppression and exclusion of individuals and groups by institutions and society that leads to discrimination against people’.

VULNERABLE GROUPS OF CLIENTS OF NORTH DUBLIN PRIMARY HEALTH CARE SOCIAL WORK
As Primary Health Care Social Work is a generic service (IASW 2011: 7), it is argued here that this type of social worker occupies a suited position to offer broad and valuable observations of how economic austerity is affecting social work clients and identify which groups of clients are most vulnerable because of such deficiencies. Primary Health Care Social Worker Ann Moroney, Student Social Worker Emma Feehily, and the author organised this project and team members of North Dublin Primary Health Care Social Work were invited to share their experiences. The following ‘at risk’ groups and some barriers facing them were identified:

1) Families with children:
Narrow family support services criteria.

- The Disability Federation of Ireland (2013) report that Family Support which supports people with disabilities living in the community is expected to experience a funding cut by €2 million in 2014.
- It has been noted that family support is prioritised to families linked in with child protection services, and given the current limited resources available to family support services some families are not receiving the extra support they are in need of.

Unavailability of special needs assessments and early intervention services for pre-school children.

- Barnardos (2006: 4) maintains that in Ireland there are long waiting lists for pre-school special needs assessments and where these have been completed the children often have to join another long waiting list to access services (e.g. speech and language), resulting in a very slow process.
- The Irish Times (O’Brien 2014) reports that according to official Health Service Executive figures there
are presently 2,090 children waiting at least twelve months for occupational therapy services, 1,940 waiting a year or more for a speech and language assessment, and a further 2,983 had already been assessed as requiring a speech and language service but have been waiting at least a year without a response.

2) People experiencing housing issues:
Inaccessibility to private-rented accommodation due to receipt of rent allowance
- Since 2011 rents in Dublin have risen by 18% and the rent allowance payable by the Department of Social Protection has fallen by 28% (McVerry 2014).
- Moreover, in November 2009, there were 6,700 units of accommodation available for rent in Dublin, while in November 2013, there were only 1,500, and 2,500 people were chasing those 1,500 units (McVerry 2014). Thus, as the demand for such accommodation far exceeds supply, landlords can choose their tenants and only about 1% of landlords are accepting people receiving rent allowance (McVerry 2014).

Paucity of social housing being built
The Irish Times (McVerry 2014) reports that between 2007 and 2011 there was a 90% decrease in social housing output, resulting in a 100% increase in the social housing waiting list from 43,700 in 2005 to 89,900 in 2013.

3) Older Persons:
Lack of supported accommodation for older persons
- Fold Ireland’s supported housing services in Glasnevin (‘Anam Cara’) and Clonsilla (‘Cherryfields’) provide 112 units of supported accommodation for older people (Fold Ireland 2014a; Fold Ireland 2014b). According to the Census 2011 there were 19,861 persons aged 65 years and over in Fingal (CSO 2011a) and 66,490 persons aged 65 years and over in Dublin City (CSO 2011b). It is clear by these figures that those who cannot or do not wish to live independently, yet cannot or do not wish to access nursing home care face a barrier in accessing supported accommodation services. According to the National Positive Aging Strategy (DOH 2013: 12), ‘older people mirror the rest of the population in their diversity and individuality’, therefore it is argued here that they deserve further choice in their accommodation type and level of support.

Decrease in nursing home placement availability.
- Nursing Homes Ireland (2013) reported in August 2013 that over 1,500 people assessed as requiring nursing home care were awaiting Fair Deal placement, with the average waiting time six to seven weeks.
- Research by CARDI (2012: 2) finds that by 2021 the number of people aged 65 years and more using residential long term care will rise by 12,270 in Ireland, which is an increase of 59% since 2006.

Cuts to home care packages and discontinuation of home help.
- In their national survey, the Neurological Alliance of Ireland (NAI) (2014: 9) found that 41% of the 601 respondents have been significantly affected by cuts to home care packages.
- Age Action (2013) report that in 2013 there was a loss of 900,000 home help hours.

4) People with a Neurological Condition:
Patients discharged from hospital into the community without specialist supports due to a “non-traumatic” acquired brain injury, e.g. stroke, damage to brain tissue due to brain tumour or surgery, etc.
In their national survey of 601 respondents with a neurological condition and their family members, NAI (2014: 8) found that 33% were dissatisfied with the support given to them in linking to services and 34% were dissatisfied with the support given to them in getting referred to services (NAI 2014: 12).

Moreover, 46% stated that it has been more difficult to access a day service appropriate to the needs of the person with the neurological condition over the past three years and 27% have not been able to access such a service at all (NAI 2014: 8). 45% reported that it has been more difficult to access respite care in the past three years and 25% have not been able to access this service (NAI 2014: 8).

Recommendations
1. Separate family support services for families experiencing issues not categorised as child protection, e.g. disability.
2. Development and expansion of special needs assessment and early intervention services.
3. Higher rate of rent allowance payable, further supply of private-rented accommodation, and incentive for landlords to accept rent allowance.
4. Greater supply of social housing to meet high demand.
5. Further supply of supported accommodation for older persons.
6. Increase in the availability of placements in nursing homes.
7. Replenishment of home care packages and home help.
8. Development and expansion of neurospecialist services.

For these recommendations to be implemented it is argued here that further social work and client advocacy is necessary. Advocacy has been defined as involving ‘a person(s), either a vulnerable individual or group or their
agreed representative, effectively pressing their case with influential others, about situations which either affect them directly or... trying to prevent proposed changes which will leave them worse off" (Brandon 1995b: 1, cited in Brandon and Brandon 2001). NASW (2014b) maintains that social workers can practice macro advocacy via active participation in the political process, lobbying, organising local protests and sit-ins, networking with other agencies, media involvement, and community organising. Classroom to Capitol (2014) offers various pragmatic means by which social workers can carry out advocacy in a simple, safe, and legal manner: write letters, call, or send emails to elected officials; follow news coverage of political or policy issues and commit to respond to press releases or letters to the editor; engage clients via invitation to participate; sign up for legislative alerts from similar-minded organisations; and establish committee of staff, clients, and community to discuss common concerns, or electronic way of tracking systemic problems. Writing for The New Social Worker, Belluomini (2014) argues that a modern form of advocacy is digital advocacy which "creates a manageable way to connect to client interests with activism for their empowerment", for example blogs, websites, mailing lists, social media options, newsletters, and educational videos (Belluomini 2014).

CONCLUSION

In conclusion, it is clear that recently published literature and reported statistics support North Dublin Primary Health Care Social Work’s identification of vulnerable groups of clients due to inadequacies in service and social payment provision. Families with children, people experiencing housing issues, older persons, and people with a neurological condition have been identified as those especially ‘at risk’. There are various means by which these inadequacies can be addressed, thus further social work social justice research and advocacy is recommended in light of this.

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References:


About the author
Alison Duggan completed her second year Masters in Social Work placement in Primary Health Care in North Dublin. Currently she is seeking employment in Social Work and will be graduating as a Professionally Qualified Social Worker in June 2014.
EXPLOITING CHILDHOOD: HOW FASTFOOD, MATERIAL OBSESSION AND PORN CULTURE ARE CREATING NEW FORMS OF ABUSE.


“There can be no keener revelation of a society’s soul than the way in which it treats its children”.

(Nelson Mandela).

This is a very well researched book and one that sends a strong message to parents and to professionals working with and interested in the welfare and protection of young people. It is alarming in its content and the message it conveys. It poses a very serious question, and asks whether corporate, commercial and sexual exploitation is a form of child abuse.

The book aims to explore the view that such exploitation should be considered a cause of ‘significant harm’ to children – a specialist term within child protection that distinguishes an action to be so harmful as to constitute a form of abuse.

Wild begins, “This book has been written to describe the emerging problems and dilemmas associated with the widespread and insidious exploitation of children today, across all sections of society”. He indicates at this early stage of the book that some of “the material may be shocking, perhaps provocative in places, but it’s overall aim is to make you think, and question your own assumptions about our collective responsibility for the welfare of children in society today”. (P.17). This first chapter sets the tone for the following chapters.

The book sets out to broaden our concept of the fundamental causes of harm to young people. “Whilst physical and sexual abuse, emotional neglect and other forms of maltreatment will always be a major concern”, we have to accept according to Wild, that “the wider cultural and economic environment is also contributing to the horrifying levels of distress that surveys consistently find”. (P.11).

It raises the debate about issues and concerns in relation to the potential for abuse of children and young people across a specific range of contexts.

Chapters 2-14 are written by a collection of authors, outstanding in their own right as both academics and practitioners in their fields. The chapters make an impact, as they set out to establish the basis for Wild’s argument. I found the following chapters to be of particular interest;

Chapter 2, by Professor Agnes Nairn looks at how marketing to children affects their relationships with the most important people in their lives, their family and friends. She offers some very useful suggestions for interacting with children and building their resilience to commercial pressures and consumerism.

Chapter 3 by Tim Lobstein looks at the link between a food industry, which encourages over consumption of junk food and poor health outcomes in young children. Chapter 6 is particularly interesting as the author, Renata Salecl poses an important question,

“How are children and young people to manage their emotions and aspirations in a world so engulfed by the magic of consumerism and the internalized notion that everything is possible?” (P.98).

She indicates that whilst seemingly positive, it has on the contrary left young people overcome with anxiety and doubt.

Chapter 8, by author Dr Gail Dines and Chapter 9 by Sharron Girling Obe are shocking. The former looks at how our culture is potentially grooming young children and in particular young girls, for sexual victimisation. The latter looks at headline statistics relating to the scale of internet use and abuse.

Chapter 12 by Stephen D Brookfield is an excellent chapter where he espouses critical thinking, that is, ways to teach and cultivate this in young people so that they can begin to challenge dominant ideologies. This theme runs into the next chapter, where Stephen Haff presents evidence to us of a different way of interacting with young people, allowing them to regroup, rethink and escape the pressures that exist in modern society.

Wild concludes by pulling the preceding chapters together, to remind us of the purpose that he set out at the beginning. He reminds us of its primary objective, “to pose a controversial question: has commercial, corporate and sexual exploitation reached such undesirable and crazed levels that children and young people are now significantly harmed by the effects?” (p.203).

This is a reflective and well-written book. The facts, for the most part are known, but presented in this way, highlight the scale of the problem. This book is a call for intervention; we should heed it!

Tracey Mc Kenna, BSW, NQSW, Grad Dip Psych.

Head of Social Work, St Michael’s House.
Mindfulness is extremely 'hip' at the moment, with frequent articles in newspapers and magazines extolling the virtues of using mindfulness in everything from the way we eat, to the way we exercise to the way we build houses. A quick Google of the term 'mindfulness' yields over five million results. There can be a temptation to regard this as faddish and somewhat superficial, in that the preponderance of articles seems to be focused on style over substance. However, in our approach to dealing with children, this book presents a powerful argument in favour of the use of mindfulness.

This book is organised into six chapters and a conclusion titled as follows: Being Reflective and Reflexive; Being Mindful; Stepping Stones to Reflective Practice; Your Story Matters; The Reflective Practice Pentagon; and Conclusion. Each chapter provides a summary at the end and North has added appendices on the UN Convention on the Rights of the Child. Ultimately North regards the goal to be 'well-managed, self-regulated, thoughtful and sensitive carers'. The purpose of the book is to assist those dealing with children and young people to develop these skills. North regards being reflective and reflexive, as skills that can be learned and developed. North proposes time out as a legitimate working tool, space to reflect and learn from events.

As I read this book, I found myself frequently speaking about it with colleagues, recommending it as an extremely useful tool in assisting reflective practice. This is a thin book and written in a light accessible style. North engages the reader from the start and, with wit and insight, ensures that the reader is convinced that her approach is both practical and obvious. Her common sense approach made me think, 'how obvious, why didn't I think of this myself and sooner'. This is not to suggest that what North is proposing is simplistic or simple to practice. Rather she challenges those of us working with children to engage with our own practice, in a deeper way, acknowledging our own motivations, weaknesses and strengths in an honest way, in order to ensure that we are more congruent and real in our dealings with children.

This book is a highly welcome and useful publication that will assist a wide variety of professionals and people who come into contact with children who have experienced trauma. North writes that her inspiration to write the book was based on a realisation that the ‘carer’s state of mind is the biggest influence on changing a child’s style of relationship’. This simple idea underpins the entire book. I found the concept refreshing and extremely useful, improving my capacity to reflect on what children I am working with are communicating and my own values and belief systems in respect of these communications.

Those of us who work closely with children will have examples where children have told us that they didn’t like someone because they were fake. Equally, we must have the courage to acknowledge the times that we workers can be fake or disingenuous with children. Our own experiences influence our motivations and values and unless we are honest with ourselves in this regard, children can and will recognise those issues that make us most uncomfortable.

North has developed what she calls the ‘Reflective Practice Pentagon’. North names the five aspects that need to work together focusing on the outcomes for the children, the quality of relationships, the synthesis of the work, the integration of the experience, transformation and the therapeutic milieu. The ‘Reflective Practice Pentagon’ comprises of the Child, the Individual [Worker/Carer], the Team, the System, and Expert Help and Theories. North outlines clearly and succinctly how each point of the pentagon interplay to work together.

I strongly recommend that this book be read by social workers, social carers and everyone who has contact with children whether traumatised or not. I have already shared it with colleagues and recommended it to others and am of the opinion that the simple but effective concepts are useful and necessary for improving our capacities to hope and visualise positive outcomes for the children we may come into contact with. Unless we actively carve out space to reflect we cannot learn or develop our practice. This book provides the reader with practical and useful tools to start the process. In conclusion if you can’t buy this book, beg, borrow or steal it!
ALL BORN UNDER THE ONE BLUE SKY IRISH PEOPLE SHARE THEIR ADOPTION STORIES

Cúnamh Original Writing Ltd., Dublin, 2013.

Reviewed by Sandra Boland BA (Hons) Public Management (Administration of Justice) LMSW NSW

‘All Born Under The One Blue Sky’ was published to acknowledge Cúnamh’s centenary. Cúnamh is a registered charity and voluntary agency part-funded by the State and was originally known as The Catholic Protection and Rescue Society of Ireland (C.P.R.S.I.), having been founded by a group of lay Catholics. The C.P.R.S.I. provided short and long-term care for children and families as well as financial help. Cúnamh became a registered adoption agency in 1952 with the introduction of legal adoption and now operates under the Adoption Act 2010. Cúnamh has expanded its services in recognition of the fact that adoption can have life-long consequences and now provides ongoing post adoption counselling, support, information and trace services.

The book is divided into four main sections of stories, stories from Birth Parents, Adoptive Parents, Adopted Persons and Others which includes stories from employees of Cúnamh. It also includes illustrations by Erin. The foreword by Professor Mary McAleese speaks of a backdrop of lives shaped by a forceful culture of shame around illegitimacy and powerlessness around poverty. It is clear however that Cúnamh was a light in the darkness, a highly regarded service provider, a vital link and support throughout the years for those going through a very difficult process in what was a largely unsympathetic, harsh culture. Cúnamh is an Irish word meaning help and it certainly lived up to its name, from my reading of the book.

The stories are beautifully told but often difficult to read as it is impossible not to be moved by the pain of what were essentially fractured families and the life-long implications that arise from this. There is great joy though too in the formation of new families through successful placements, later reunions, expanded families and working through the many difficulties to come out the other side, with the essential support of Cúnamh a key factor. Important and recurring themes include the necessity for an appropriate degree of open adoption, the need and the right of those adopted to know their origins and background and of birth parents to know how their children progress. What is very clear is that when these aspects are not worked through as well as possible rather than in a vacuum of information, enforced or otherwise, the associated trauma, pain and damage are immensely compounded. The issues are summarised best by those who have direct experience in the following extracts:

Eileen: “I was not married and my parents were becoming ashamed of me, I thought. Looking back now 39 years, they were protecting me from a backward nation, stigma and conventionality. They did not want me exposed or hurt. Wrong again. This hurt never goes away.”

Geraldine: “As a devastated, guilt-ridden, full of shame and heartbroken mother I was determined that if ever my baby wanted to contact me, I would make finding me as easy as possible and to make sure that there would be no doubt about my response of love should this happen.”

“In all of us there is a hunger, marrow-deep, to know our heritage—to know who we are and where we have come from. Without this enriching knowledge, there is a hollow yearning...and the most disquieting loneliness.”

Alex Haley, Author of Roots.

One of the contributors Nicola notes a particular film as a very helpful tool in this regard: “For me the seminal portrayal of adoption and the dilemma that the need to know gives rise to is the film ‘Secrets & Lies’... It is challenging and moving and ultimately uplifting, giving voice to what is often a harrowing journey of self-discovery for both parties.”

Finally, while the adoption experience is a unique one with its own particular and often severe difficulties and each person’s experience of it also unique, it was clear to me having read the book that anyone who has had experience of a fractured family in any form can strongly identify and empathise with the pain involved. Having come from a broken home myself and losing my own wonderful mother recently I knew the pain very well, though it took a different form. I hope that my saying that will help those living with the pain of adoption to feel less isolated in their journey through the difficulties. Fractured families and recovery come in many guises and family is defined more by love than by biology. As I said in tribute to my mam: “She was my best friend not because she was my mam but because she had all the ingredients to be the very best of best friends.” I want to thank all of the contributors and Cúnamh for what is a truly worthwhile book for all of us!
Irish Association of Social Workers' Code of Ethics

1. The social worker’s primary focus is the needs of the people using the social work service. While respecting the social, cultural and environmental context in which they live, this focus must recognize, take account of and balance possible conflicts between their needs and the human rights of different individuals and the communities in which they share their lives. This focus must take precedence over the self-interest and personal convictions of the social worker.

2. Constraints such as poverty, inequality or discrimination may constrain service user’s ability to fulfill their needs. These constraints cannot always be resolved at the level of the individual. Social workers will advocate with and on behalf of those whom society excludes and in doing so should engage with service users and facilitate them in contributing their views to such developments. In addition, social workers should use their professional association as a forum for critical debate and dialogue with other professional agencies, the government and the public at large, to advocate for and to promote positive social change.

3. Social workers in focusing on individuals, groups and communities in which they live will be aware of the potential power imbalance in the relationships that follow. Social workers will strive to use their power appropriately within such relationships and will place special emphasis on the consideration of and promotion of service users’ views in all decisions that are related to the quality of their lives. Social workers will promote the participation of service users in order to maximise the potential of any service user or group for self-determination now and in the future.

4. The practice of social work operates within systems that have a regulatory function. Social workers must be cognizant of the inherent tensions between support and control that may arise. In addressing such tensions, social workers will at all times strive towards the objective of the service user maximising their own ability to make and carry out decisions affecting their quality of life.

5. Social workers must aim continuously to achieve high standards of professional practice in pursuit of which they will engage in Continuing Professional Development by undertaking further training and education on a regular basis and take active steps to ensure that they receive appropriate supervision.

6. Social workers engaged in education, training or supervision will seek to ensure that their professional relationships in these areas are constructive and non-exploitative and will foster knowledge and understanding of the social work profession and this Code.

7. In seeking to respond to the needs of individuals, groups and communities social workers will seek to involve other professionals and agencies as appropriate.

8. Social workers, having taken into account the rights of others, will provide service users with full information, including access to records pertaining to work on their behalf. Social workers should be prepared to state the reasons for their decisions and be accountable for them.

9. Social workers will respect a service user’s right to confidentiality in the social worker/service user relationship. It is the duty of the social worker to ensure that the nature and limits of the privacy inherent in their relationship are clearly understood and applied. In particular, social workers must inform service users:

- Of the circumstances in which information relating to the service user will be disclosed on a ‘need-to-know’ basis with other colleagues and agencies;
- That their views regarding disclosure of any information relating to the service user will always be sought;
- That disclosure of information against the service user’s wishes will occur in clearly defined circumstances such as those required by law, or for the protection of a service user or for the protection of a third party.

Our Code of Practice is available on www.iasw.ie